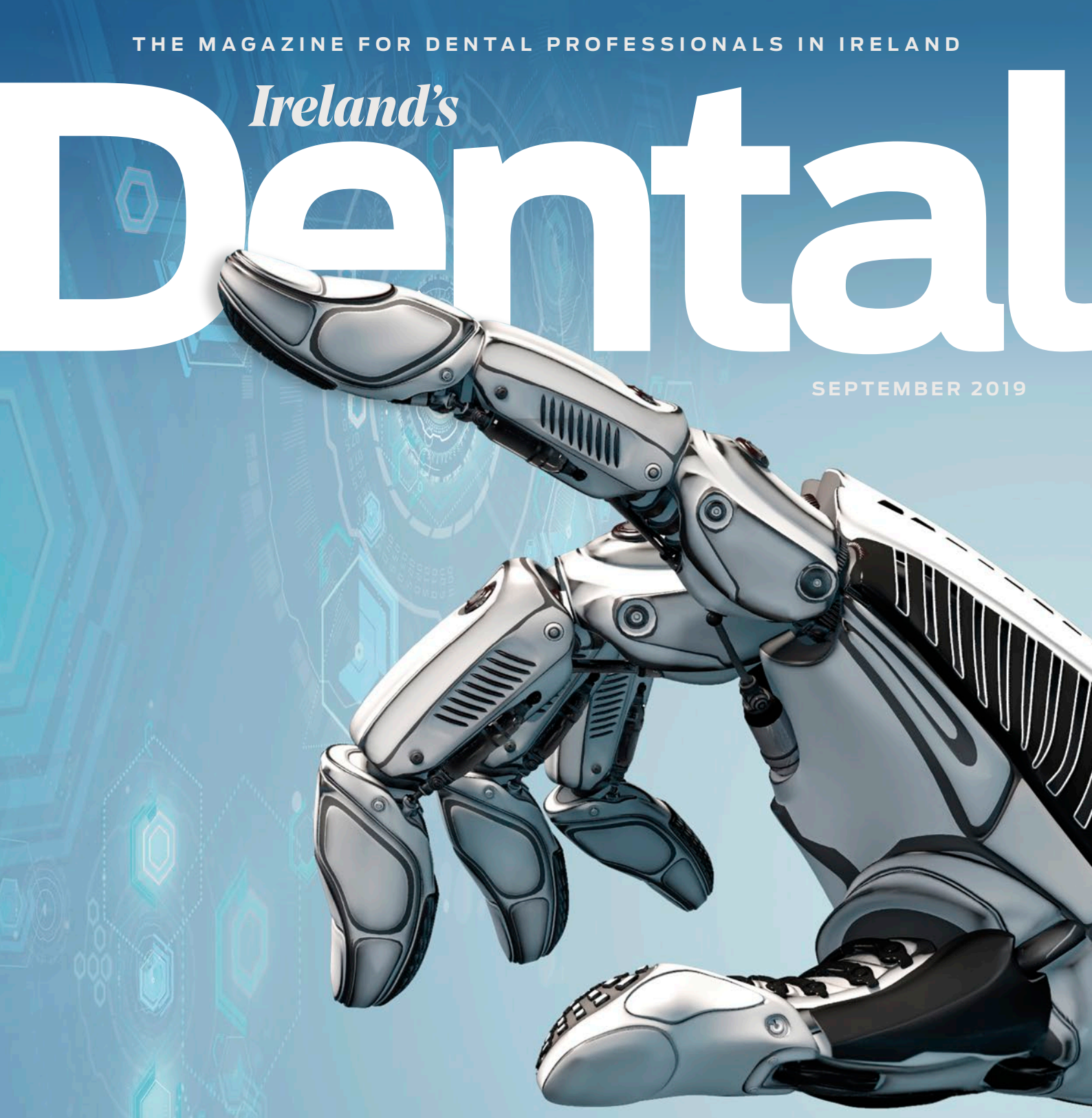
THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

Ireland's Dental

SEPTEMBER 2019



A vision for the *future*

Rethinking oral health policies north and south

SEPTEMBER 2019

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THE MAGAZINE FOR DENTAL PROFESSIONALS IN IRELAND

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It's time to start talking

Dental professionals, health specialists and politicians will gather at Stormont later this autumn for a summit designed to be a "watershed" moment in oral health policy in Northern Ireland. Delegates will hear from Simon Reid, Chief Dental Officer, Michael Donaldson, head of dental services at the Health and Social Care Board, Gerry McKenna, adjunct professor at the College of Medicine and Health, University College Cork, Caroline Lappin, chair of the BDA's Northern Ireland Council, and Roz McMullan, the BDA's national president. The summit, says Tristen Kelso, the British Dental Association's Northern Ireland Director, is designed not just to highlight the work needed to be done, but also to start to come up with a new, more ambitious and positive vision for oral health in Northern Ireland – in collaboration with a range of key stakeholders. Northern Ireland faces incredible challenges when it comes to oral health and tackling these challenges requires vision, ambition and investment, he argues, from both Stormont and Westminster. Oral health, and especially children's oral health, needs to be a stated priority of the Department of Health, and resourced accordingly. The Department of Health's 2007 Oral Health Strategy needs to be evaluated, updated and underpinned by the latest evidence.

There needs to be a commitment towards a new comprehensive oral health strategy with considerably improved oral health outcomes for key sections of the population, including children, to be included within any future Programme for Government. It is the start of a journey, and frank debate is key. The Republic of Ireland, however, is at a different stage; earlier this year, the Government launched Smile agus Sláinte. The policy is wide-ranging and takes an "intersectoral approach" as well as being consistent with the primary care philosophy of prevention, treatment at the lowest level of complexity and recourse to specialist care where clinically appropriate. It is, a Department of Health official said, the "culmination of a comprehensive programme of research, analysis and consultation over a number of years and, over time, we will update models of care and service delivery that have been with us for 25 years or more".

> "POLITICIANS ARE AT A LOSS OVER HOW THE IDA AND THE DEPARTMENT OF HEALTH COULD HOLD SUCH DIVERGING VIEWS OF THE CONSULTATION PROCESS"

Which makes the recent stance of the Irish Dental Association (IDA) difficult to understand. Fintan Hourihan, its chief executive, complained: "The association was not invited to participate and nor was it consulted in a manner any way consistent with the terms of the agreed information and consultation agreement for the HSE [Health Service Executive] and its staff in preparation of the new oral health policy. We only saw its contents for the first time on the date of its publication." It is a view that has flummoxed Dr Dympna Kavanagh, Ireland's Chief Dental Officer (CDO). "We had briefings and engagements with the association," she said.

When *Ireland's Dental* magazine put a series of questions to the chief executive seeking to clarify its position, an official said he would only be commenting to the IDA's journal. A close inspection of its summer edition shed no light on the contradictory standpoints. Trawling through its archives revealed a photograph and accompanying story describing the IDA's involvement in a stakeholder event used to inform the policy. Politicians are at a loss over how the IDA and the Department of Health could hold such diverging views of the consultation process. They have called on the organisations to "re-establish" their relationship.

It is, indeed, time to start talking.

Dr Paul O D'wyer BDS MSc (Healthcare Mgmt)

Everybody else is doing it, so why can't we?

What defines success in dentistry? From a clinical viewpoint, dentists would usually suggest successful treatments – particularly complex treatments – such as advanced crown and bridge, implant placement or surgical removal of a troublesome tooth. This is the yardstick by which we, as clinicians, judge ourselves. Our training and experience as clinicians lead us to this inescapable conclusion.

Dentists spend significant time and expense on increased training, adapting to new materials and perfecting new clinical techniques to improve these clinical outcomes.

But what defines success in dentistry from our patients' viewpoint? Recent papers suggest that ease of access, a trusted clinician and reasonable fees are the key parameters for what patients view as success and quality care. (Tickle, M. and Campbell, S., 2013. How do we measure quality in primary dental care? *British Dental Journal*, 215(4), p.183.)

In trying to achieve success on all fronts, it is often the non-clinical aspects of our service that prove most challenging. As we are continually improving clinical performance in our surgeries – through clinical treatments – we must also focus on improvements in our patient experience. Quality improvement is different from quality assurance. The former is prospective and the latter is retrospective. From practice, we can usually clinically predict how a treatment will succeed. Think about that crumbling lower first molar, and the chances of fracture on extraction. Seasoned dentists will know that should we attempt it, then the possibility of a surgical extraction is high. We take action. We allot the sufficient time and equipment to the task. We have a considered discussion with our patient. This prepares us – and the patient – for a predictable outcome. This particular knowledge is learned through hard-fought experience chair-side. This is quality assurance in action. If we now apply this learning to the patient experience in our practice, it can be instructive to attract and maintain our patients. This is quality improvement.

Measurement is crucial to improvement. Just as we can predict clinically, from thousands of crumbling lower first molars, how the procedure will transpire, with IT in general practice in particular, we can easily summon up several reports on our working day. Many criteria can be viewed – from time spent clinically with each patient to the average time a patient spends in our waiting room. This type of review is as critical, I would argue, as the clinical success indicators mentioned above. Simply put, patients may never fully appreciate the time taken to train, provide, place and finish a composite restoration – but will always appreciate being seen in a timely manner. The opposite of the above is also true. How often have we "gone the extra mile" for a patient (who has been kept waiting) to be met with stony silence at the end of a long restorative visit?

The idea of combining the management of a practice with the clinical acumen of the practitioner is not new. However, its study (and improvement) is still relatively in its infancy. This is not to say that gilt-edged practice management alone will lead to success in dentistry – if there is absence of successful clinical outcomes! By the same logic, it is evident that a partnership or combination of management and clinical skills seems to lead to overall success in dentistry. It satisfies the crucial clinical success indicators that we have trained to provide, and the practice management indicators that we sometimes "strain" to provide!

In applying the SMART goals theory of Specific, Measurable, Achievable, Realistic and Timely, we can implement key improvements to our individual practices. A classic example here is the old chestnut of waiting time for patients. Delays in dentistry are inevitable – with chips, breaks and infections – particularly in the Summer months when patients are more likely to be outdoors. This aside, the routine appointment schedule can be adapted to absorb these delays. By applying the SMART goals theory, take a look at your last week of appointments. How long was the average wait for your patient? What caused these delays? Can we reduce these? Aside from my Group Clinical Advisor role with Dental Care Ireland, I am also Adjunct Faculty at the Institute of Leadership at the RCSI. In teaching Masters candidates at RCSI, we use the SMART goal theory to overcome challenges e.g. 80% of patients (Specific and Measurable) will be seen within 5-10 minutes of their appointment time (Achievable, Timely and Realistic). This example, can dramatically improve patient experience – and their view of your practice. As you implement changes, you can record them – and, like other organisations, demonstrate these goals. Goals that others may not even be measuring. Industry has shown such statistics to be a key driver in the choices patients/people make. In thinking about success in dentistry, I am reminded of those organisations – and of the title of a classic The Cranberries album – *Everybody Else Is Doing It, So Why Can't We?*

NI's sugar tax is a 'wasted windfall'

Northern Ireland should follow the lead of pioneering programmes in Wales and Scotland, says the BDA

WITH the Soft Drinks Industry Levy facing an uncertain future, the British Dental Association Northern Ireland has urged Stormont authorities to "get a grip" and use the windfall to improve children's health.

The BDA has previously highlighted that, owing to a lack of functioning government, the £12.3m raised from the levy has "disappeared into a black hole". Devolved governments were given full discretion on where to spend the proceeds. However, the Northern Ireland Department of Finance has confirmed that "the 2018-19 funding was not ring-fenced for any particular purpose".

The BDA has called for Northern Ireland – which has worst decay rates in the UK – to invest in children's oral health. It should, says the organisation, follow pioneering programmes from devolved governments in Wales and Scotland which have shaved millions off treatment costs through dedicated early years oral health programmes.

Seventy-two per cent of 15-year-olds in Northern Ireland have tooth decay compared with 44% in England, and 63% in Wales. Northern Ireland hospitals face a bill of more than £9.3m a year for paediatric tooth extractions.

"The current debate on the future of the sugar tax is a red herring in Northern Ireland," said Caroline Lappin, BDA NI Council Chair. "Not a penny of this windfall has been spent in the spirit that was intended. Funds that should have been invested in improving children's health have been spent helping Stormont accountants get their books to balance.

"A fraction of these proceeds could have transformed the oral health of the children who currently top the UK league table for tooth decay. All dentists would mourn the passing of the sugar levy. But the sad truth is – when it comes to actually helping the young in Northern Ireland – it has never really existed.

"Our children's oral health is too important to be allowed to drift along any longer; that is why it will be a key theme at a forthcoming BDA Oral Health Matters summit to take place at Stormont in the autumn".

Tristen Kelso, the BDA's Northern Ireland Director, added: "This summit is designed to not just to highlight the work we need to do, but to start to come up with a new, more ambitious, vision for oral health in Northern Ireland - with full support from a wide range of key stakeholders.

"Northern Ireland faces incredible challenges when it comes to oral health and tackling these challenges requires vision, ambition and investment - from both Stormont and Westminster. Oral health, and especially children's oral health, needs to be a stated priority of the Department of Health, and resourced accordingly."

A vision for oral health in Northern Ireland, P34

IDA and DoH told to rebuild relationship

Standoff between IDA and government leaves Parliament confused

POLITICIANS have called on officials at Ireland's Department of Health and representatives of the Irish Dental Association (IDA) to clarify their relationship after the country's Chief Dental Officer rebutted claims by the IDA that it had not been consulted during the development of the new oral health policy.

Fintan Hourihan, the IDA's Chief Executive, told a meeting of the Parliament's Joint Health Committee earlier this year: "The association was not invited to participate and nor was it consulted in a manner any way consistent with the terms of the agreed information and consultation agreement for the HSE [Health Service Executive] and its staff in preparation of the new oral health policy. We only saw its contents for the first time on the date of its publication [in April]."

However, at a subsequent meeting of the committee over the summer, Dr Dympna Kavanagh, Ireland's CDO, said: "We had briefings and engagements with the association. On the policy specifically, we met the association in 2018 and 2019, where we gave it a comprehensive briefing of the policy and an overview of the ethos. We then met it again [this year] before the policy was launched."

The standoff has left politicians confused. "There is an element of clarification or relationship building required," said John Brassil, Fianna Fáil's spokesman on primary care and community health. "What is being fed into the political system by the Irish Dental Association is that it is not overly impressed with the consultation process on this strategy. [The IDA] is telling us that it was not properly consulted. Whether that is factual, I do not know but it is out there in the ether."

Sinn Féin's health spokeswoman Louise O'Reilly added: "I struggle to understand how we can have two people in for two different sessions who can have such completely divergent views of the same process. In the absence of a time machine it cannot be fixed, but it is important that the relationship is re-established."

Professor Brian O'Connell, Vice Chair of the policy's academic reference group, commented: "Over the years the association and many other associations have produced much of their own documentation, policy suggestions and recommendations. We considered all of them and one will find a great deal of crossover between the consistent recommendations of bodies such as the Irish Dental Association and what is in the policy. I speak to dentists every day. Their concerns are largely about the implementation of the policy rather than the policy itself. They ask whether there will be enough funding for it, whether the entire policy will be implemented and so on."

Smiles all round? P16

Dental check shunned

HUNDREDS of thousands of people in Ireland are not taking advantage of a state benefit scheme offering free or discounted dental, optical and hearing care. Some 2.5m people pay PRSI, which entitles them to services such as a free dental check-up once a year. However, more than two-thirds of those who qualify did not avail of the entitlement last year, while an even smaller number sought free eye and hearing exams and related equipment.

Tipton awarded accreditation

THE Royal College of Surgeons of England (RCS) have awarded Centre Accreditation to Tipton Training for its courses in the UK and Ireland. It becomes the first private postgraduate dental education provider in the UK to have an RCS England accredited centre. Tipton underwent a comprehensive review from an RCS panel, formed of subject matter and quality assurance experts. Specifically, areas such as facilities, resources and faculty, education portfolio and infrastructure and quality management processes were assessed.

UCC dental school gets the go-ahead

UNIVERSITY College Cork has been granted permission to build a new multi-million euro dental school in the western suburbs of the city.

The project is designed to provide dental health services, clinical teaching spaces for dental students along with education and support facilities, research laboratories and innovation spaces.

"The ambition is that the building, built over two phases, will provide a welcoming and comfortable experience for patients, a creative learning environment for students and a positive working environment for staff," said a spokesman.

The five-storey dental hospital will have research and innovation facilities, a central sterile services department, roof top plant enclosure and support service areas and will be served by a new roads network. It is hoped that construction will start on site sometime next summer and the project is expected to be completed in early 2022.

Alarm over three-year-olds' sugar rush

Youngsters consuming double the WHO recommended limit

RESEARCHERS from the Dublin Dental University Hospital at Trinity College have found that three-year-olds in Ireland are consuming on average 10 level teaspoons of 'free sugars' – those added to processed food and those naturally occurring in fruit juices and so on – a day; more than double the amount recommended by the World Health Organisation.

The study, published in the *European Journal of Nutrition*, used a modified algorithm to estimate the free sugar intake in Irish three-year old pre-schoolers using data from the National Preschool Nutrition Survey (NPNS) and the Growing Up in Ireland survey (GUI). The results indicate that 75% of three-year-olds had free sugar intake greater than the maximum recommended by WHO guidelines for free sugar intake, while only 4% met the lower threshold.

The ideal recommendation by WHO is to further reduce the amount of free sugar to a maximum of four-to-five teaspoons, if possible, and aim towards a maximum frequency of once per day of sugary foods and drinks.

'Fruit juices and smoothies', 'dairy products' (including yoghurts and fromage frais), 'soft drinks' (including squashes, cordials and fruit juice drinks), 'confectionary' (chocolate and non-chocolate) and 'cakes and biscuits' were the key food sources for free sugar, contributing to more than three-quarters of total free sugar intake.

Michael Crowe, lead author of the study, said: "Free sugar intake is excessively high, even at this early age, and reducing the consumption, especially snacking, of low nutrient, discretionary food and drink should be a helpful approach to achieving an overall reduction in free sugar consumption."

He said children's snack choices are dominated by foods high in free sugars so substituting these snacks with healthier alternatives would seem one obvious dietary strategy to help reduce free sugar intake. The study shows that 'chocolate' and 'non-chocolate confectionary' and 'cakes and biscuits' are commonly consumed as snacks, which means that they could be cut or replaced with healthier alternatives in order to reduce the frequency and amount of sugar throughout the day.

The results have relevance for both the general and oral health of pre-schoolers as a high sugar intake affects both aspects of health. As well as concerns about establishing unhealthy eating patterns at an early age that may influence obesity risk, sugar intake is a key risk factor in the progression and reversal of early dental caries. The prevalence of oral health problems in young children has increased in recent years, following a decline in previous decades. Early childhood caries is the most prevalent dental problem in pre-schoolers, one of the most common causes of hospital admission and the most frequent reason for unplanned general anaesthesia in children.

As highlighted by the team's analysis and that of previous researchers 'RTEBC' (ready to eat breakfast cereals) and 'fruit juices' are items of consumption that have become difficult to classify as 'healthy' or 'unhealthy' as they can be an important source of nutrients for young children but also contain relatively high levels of free sugar. The analysis also highlights the lack of standardised methods for free sugar estimation and the importance of using appropriate methods for quantifying sugar intake at the food level.

Currently, food manufacturers in the EU are not required to include free sugar content in their labelling which makes it difficult for consumers to quantify their consumption. It is also difficult for consumers to understand the different types and sources of dietary sugars and questionable as to whether they could use this information to attempt to meet the WHO guidelines.

The researchers say the findings should help dentists and dental hygienists to understand the specific food and drink patterns to focus on when carrying out dietary risk assessment and counselling for pre-school children and to be aware that most children do not meet the WHO population guideline.

Source: Estimation and consumption pattern of free sugar intake in 3-year-old Irish preschool children. Crowe, M. O'Sullivan, M. Cassetti, O. et al. Eur J Nutr (2019). www.doi.org/10.1007/s00394-019-02056-8

Past Dean recognised

DR John Walsh, Immediate Past Dean of the Faculty of Dentistry, RCSI was recently presented with the 2019 Distinguished Alumnus Award of the Indiana University Paedodontic Alumnus Association in Chicago. The award was in recognition of his contribution to the profession of Paediatric Dentistry and to Indiana University.

Pension access welcomed

BDA Northern Ireland has welcomed a new facility that will give GDPs online access to their annual allowance statements and annual benefit statements, which has been launched by HSC Pension Service. Accessed via a secure hscni.net email account, HSC Pension Service has committed to start making annual benefit statements available on the new member self-service facility from September, with a roll-out of annual allowance statements from October.

DATES FOR YOUR DIARY

3 SEPTEMBER
BDA NI: How to improve endodontic success rates in general practice
Malone Lodge Hotel, Belfast
BT9 6DY

19-21 SEPTEMBER
British Orthodontic Conference 2019
SEC Glasgow
More information at:
www.bos.org.uk/BOC-Glasgow-2019-Programme

20-22 SEPTEMBER
BDA NI: Scientific Weekend & Challenges in Endodontics Lecture
Rosapenna Hotel and Golf Resort

26 SEPTEMBER
Medical & Dental Training Agency: Clinical Education Day
Riddel Hall, Belfast

27 SEPTEMBER
IDA: Snoring and the role of the GDP
Leopardstown Office Park, Dublin

5 OCTOBER
Dental Protection Conference 2019
The Convention Centre, Dublin

8 OCTOBER
BDA NI: What GPs need to know about persistent pain after dental procedures
Malone Lodge Hotel, Belfast
BT9 6DY

10 OCTOBER
Ireland's Health Services Dental Surgeons Seminar
Midlands Park hotel, Portlaoise,
R32 KV20

12 OCTOBER
BDA Northern Ireland Gala Ball
Titanic Hotel, Belfast BT3 9DT

14 OCTOBER
Irish Society of Periodontology: Annual Scientific Conference
Westin Hotel, Dublin

17 OCTOBER
Medical & Dental Training Agency: Trainee Research Day
Postgraduate Centre, Belfast
City Hospital

1-2 NOVEMBER
Annual Scientific Meeting of the Faculty of Dentistry of the RCSI
RCSI St Stephen's Green Campus,
Dublin 2
More information at: asm2019.ie

8-9 NOVEMBER
IDHA Winter Scientific Conference
Radisson Blu Hotel, Limerick

12 NOVEMBER
BDA NI: AGM
Malone Lodge Hotel, Belfast
BT9 6DY

12 NOVEMBER
BDA NI: How to get published
Malone Lodge Hotel, Belfast
BT9 6DY

14 NOVEMBER
RCSI: Diploma, Masters and Doctorate Conferring Ceremony
RCSI Exam Hall, Dublin 2

22-23 NOVEMBER
Orthodontic Society of Ireland: Autumn Meeting & AGM
Convention Centre, Lyrath Estate,
Kilkenny

** More information for RPCSG events at: https://rcpsg.ac.uk/events*

***More information for RCSEd events at: www.rcsed.ac.uk/events-courses*

****More information for BDA events at: www.bda.org/events*

 # More information for RCSi events at: http://facultyofdentistry.ie/postgraduate-programme/upcoming-events

Oral Health Policy

Smiles all round?

Despite claim and counterclaim over the Irish Government's engagement with dentists, roll-out of the new oral health policy has begun

WORDS
WILL PEAKIN

From approval by the Government in March, through its public launch in April, implementation of Ireland's new national oral health policy, Smile agus Sláinte, is underway. But in the immediate aftermath of its unveiling, the Irish Dental Association (IDA) was quick to cry foul; not only was the policy flawed, the association claimed that it had not been consulted during its development.

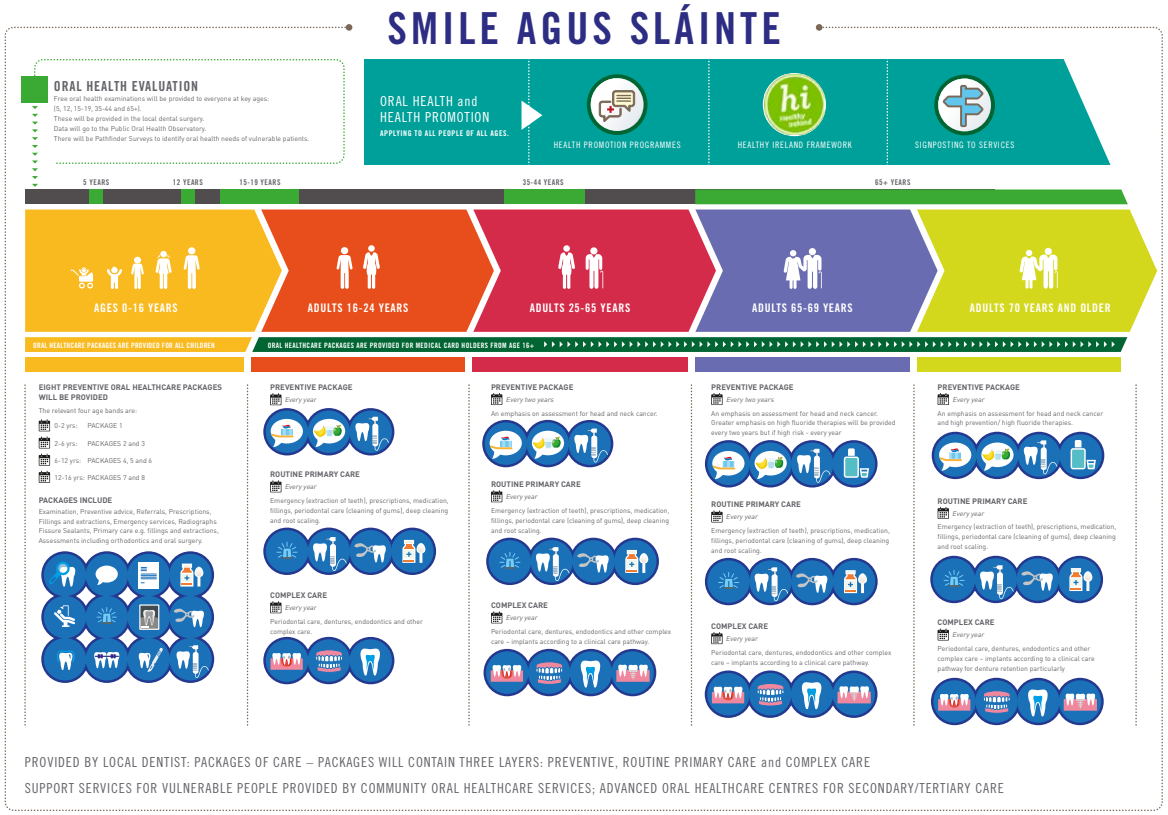
"The association represents 2,000 dentists – the overwhelming majority of dentists in practice across all branches of the profession," said Fintan Hourihan, its chief executive. "The association was not invited to participate and nor was it consulted in a manner any way consistent with the terms of the agreed information and consultation agreement for the HSE [Health Service Executive] and its staff in preparation of the new oral health policy. We only saw its contents for the first time on the date of its publication."

It is a view that has flummoxed Dr Dympna Kavanagh, Ireland's Chief Dental Officer (CDO). "We had briefings and engagements with the association," she said. "On the policy specifically, we met the association in 2018 and 2019, where we gave it a comprehensive briefing of the policy and an overview of the ethos. We then met it again before the policy was launched."

Kavanagh said that IDA representatives had previously attended a stakeholder day and led some of the roundtable discussions. "We also carried out a year-long structured engagement for dentists and salaried services," she added. "There were intensive, structured, interviews analysed by the University of Sheffield. Many of those who participated were Irish Dental Association members."

Professor Brian O'Connell, vice chair of the policy's academic reference group, added: "Over the years the association and many other associations have produced much of their own documentation, policy suggestions and recommendations. We considered all of them and one will find a great deal of crossover between the consistent recommendations of bodies such as the Irish Dental Association and what is in the policy. I speak to dentists every day. Their concerns are largely about the implementation of the policy rather than the policy itself. They ask whether there will be enough funding for it, whether the entire policy will be implemented and so on."

As detailed in News (P11), politicians are at a loss over how the IDA and the Department of Health could hold such diverging views of the consultation process. They have called on the organisations to "re-establish" their relationship. This may, perhaps, come about through the implementation period as outlined by the Chief Dental Officer. "The implementation period is needed to commit actively to engagement on significant and complex issues," commented Kavanagh. First, she said, a framework



is required "to support long-term sustainability" of the policy. A review of undergraduate and graduate education "is a priority", said Kavanagh, along with the establishment of a system of career-long mentoring. There will also be a focus on "legislative issues", specifically to update the Dentists Act 1985. "The Department has already begun to discuss the priorities with key agencies, and we are agreeing targets and timescales," said the CDO.

"Implementation of a transformative policy such as Smile agus Sláinte will present challenges," she added. "All change is challenging. However, those challenges will present opportunities for the staff in private practice and the public dental service. It is important that implementation is owned by the profession while listening to the voice of the public. To achieve these priorities, we need key leadership roles operationally and in dental schools. Primary care, special care, advanced or specialist care delivery and public health leaders must be in place so that implementation is sustainable and placed where it belongs in the services."

The Government said its policy is wide-ranging and takes an "intersectoral approach" as well as being consistent with the primary care philosophy of prevention, treatment at the lowest level of complexity and recourse to specialist care where clinically appropriate. It is, a Department of Health official said, the "culmination of a comprehensive programme of research, analysis and consultation over a number of years and, over time, we will update models of care and service delivery that have been with us for 25 years or more".

The policy is not only aligned with international models of good practice but with the ideals and approach in other healthcare policy areas, such as Sláintecare and Healthy Ireland, added the official. "It is important to say that it does not seek to change all aspects of service delivery overnight," he cautioned, "but it puts in place the framework for real and substantive change on a phased basis. As with any area of public service provision, implementation will need to be planned and managed in consultation with all interested parties, particularly the dental profession, as well as all those who use and depend on the services."

About Smile agus Sláinte

It is a comprehensive and evidence-based policy informed by extensive research and consultation, said CDO Kavanagh. Its aim is to better facilitate oral health for everyone and to support continued professional development. The programme is transformative, introducing and managing a series of changes over eight years, said Kavanagh.

"The policy is aligned with other Government policies, including Sláintecare, Healthy Ireland and First 5, which is a whole-of-Government strategy for babies, young children and families, as well as the national strategies on disability and mental health," she added. "It conforms to the international policies of the WHO and the European Union. The policy embraces the 'no child is left behind' principle of First 5 and the education policies."

Kavanagh continued: "This is the first major oral health policy statement in 25 years and much has changed in Ireland in that period, including the standard of general and oral health, the materials and technology used in dentistry, and the types of services we aim to provide. In developing the policy, we have ensured that it is supported by up-to-date information about the oral health of the population, as well as by appropriate international evidence. A broad range of stakeholders was consulted,

> "IT IS IMPORTANT THAT IMPLEMENTATION IS OWNED BY THE PROFESSION WHILE LISTENING TO THE VOICE OF THE PUBLIC"
>
> DR DYMPNA KAVANAGH

including those who use the services and those providing the care.

"Our current oral health system is out of step with other Irish and international health services. There are gaps remaining in routine dental care for the very young and the vulnerable, including people in residential care, people with disabilities and older people.

"Smile agus Sláinte reorients how care is provided in line with Sláintecare so that most dental care is provided in people's own communities, as close as possible to where they live.

"This is beneficial for service users and allows acute services to focus on more complex care. What is described in Smile agus Sláinte is not a demand-led service. Instead, it enables the Irish public to access services and forge a relationship with their chosen dental practice; we call this their 'dental home'."

To support this universal primary care approach, said Kavanagh, a safety net system will identify those who do not or cannot attend their local dentist. This safety net system is part of the surveillance system outlined in the policy and ensures that the most vulnerable children and adults, including those on lower incomes, will be supported and receive the same quality of service as the rest of the population.

The existing public dental service will be stronger, she said. A key service will be to identify, support and deliver care for vulnerable children and adults when it cannot be provided in the local dental practice. The measures set out in the policy will provide professional opportunities for staff in areas such as health promotion, special care services and public health.

Kavanagh identified some of the key policy strategies and proposals. "Water fluoridation is one key reason we have such good oral health in Ireland and will remain a cornerstone of oral health policy.

"Health promotion programmes will be put in place for the whole population and to target the most vulnerable. Most children and eligible adults will be treated in local dental practices and a package for children from birth until the age of 16 will, in a phased way, replace the existing schools programme.

"It is the first time that those under the age of six, teenagers and adults will have lifetime access to preventive treatment such as fissure sealants and fluoride varnishes, as well as access to dietary advice in dental practices.

"The expansion of primary care is proposed from birth until old age, across the whole life course.

"We have focused on improving access for vulnerable groups such as those on low incomes, rural dwellers and people with disabilities. Enabling them to get to local dental practices is key. As I mentioned, the safety net service is essential to ensure that their needs are addressed, and they get comprehensive care.

"We must not forget that we need advanced care and specialist care services, and that includes the concerns around general dental anaesthesia. Monitoring systems will have to be put in place to identify people who are not taking up the services, overall dental needs and the policy's impact. There must be a full review of dental undergraduate education, in tandem with career-long professional mentoring for dentists."

A spokesperson for the Dental Health Foundation Ireland said it was "delighted that such a positive step is being taken to improve the oral health of people in Ireland". Their counterpart at the Dental Council added: "The policy presents a welcome number of opportunities to align the activities of stakeholders on a national basis to promote oral health and protect patients. The strong focus on primary care dentistry is appropriate, as is the focus on prevention and the emphasis on dental professionals working in a team structure."

Despite the IDA's issue with the extent of consultation undertaken by the Department of Health, its president, Professor Leo Stassen, commented: "[The policy] will hopefully stimulate constructive and full debate on oral health and that is a good thing. Indeed, the focus on prevention, on screening, the policy's provisions for building links between oral and general health through a common risk factor approach, its proposals on dental workforce, professional development, on research and on critical evaluation, are all positive."

But he added: "That very focus on prevention, which we welcome, will not address the significant amount of untreated oral disease that is already present. Patients with dental disease will progressively deteriorate, leading to vast resources being required to try to get them back to a status quo, and putting more pressure on already overstretched secondary care centres."

> "THAT VERY FOCUS ON PREVENTION WILL NOT ADDRESS THE SIGNIFICANT AMOUNT OF UNTREATED ORAL DISEASE ALREADY PRESENT"
>
> PROFESSOR LEO STASSEN

> “IT IS UNCERTAIN HOW SUPPORT WILL BE GIVEN TO HER DAD TO REMIND HIM OF THE IMPORTANCE OF THE CHILD’S DENTAL HEALTH”

Worst case scenario: Millie’s story

WHAT, asks the IDA, will happen to children who elude intervention because their parents don’t bring them to the dentist?

Four-year-old Millie and her eight-year-old brother live with their father who works full time in financial services. He drops them to the crèche at 8am. The staff there bring Millie and her brother to school and both of the children are collected by their dad from the crèche at 6.30pm. They go home, have dinner and then go to bed. Millie’s mother no longer resides in the family home as the parents separated due to her mother’s mental health issues. Millie’s dad manages to organise the day-to-day schedule during the school term by cooking and supervising. He states that tooth brushing does not always happen. The children sometimes stay with their mother or at the home of their grandmother.

Millie mentions to her dad that she has a sore tooth, but it is not until her face is slightly swollen and the crèche staff remind him that her dad organises a dental appointment.

As things stand, he takes time from school to bring Millie to the emergency dentist at the HSE. It is noticed there that Millie has a reasonably high rate of decay in her baby teeth and has an abscess in one of her molars.

In that situation, the HSE staff would refer Millie to a general anaesthetic extraction service, having managed the symptoms with an antibiotic. Her social circumstances are noted on the dental records and she is registered as having a reasonably high risk of future decay.

The HSE staff record that Millie and her brother will need to have a good reminder system in place. The children are placed on recall to enable support to be given to them and Millie and her brother will be targeted at intervals throughout their school years. They will also have continuous access to emergency care.

The HSE staff will arrange with the children’s dad to liaise with the crèche workers to bring in Millie for dental appointments to enable her to continue her dental care.

As outlined in this new policy, in a future version of this same scenario, while Millie will have access to care bundles, it is uncertain how support will be given to her dad to remind him of the importance of the child’s dental health. It is unclear if the children can be registered as being at risk due to the mother’s mental health issues. It is also unclear how any symptoms can be managed while Millie waits for her general anaesthetic extraction appointment.

In this new scenario, after Millie has her tooth taken out, her dad may wait until she has another toothache before bringing her to the dentist again. Millie relies on her dad to recognise the early signs of dental decay, and it is uncertain if there is any safety net for children within the new proposed structures. It is also uncertain how the new arrangements will interact with Tusla, the child and family agency.

The system in place identifies, manages and arranges treatment and referral where necessary. It also allows what presents to be recorded and a plan to be set out for the future. That is how the public service is set up. The difficulty is that the public service has been run down, with an insufficient number of dentists in place. With the best will in the world, those resources are not available in general practice and those systems of recording information, arranging care and treatment and referrals and follow-up are not in place.

We have no confidence that what is outlined in this strategy document suggests that is something that can be provided in the near future.

Real-world case; names have been changed.

Source: Irish Dental Association evidence to the Oireachtas Joint Committee on Health, 15 May 2019 (www.tinyurl.com/y23sq7nx)

IDA irish dental association

CPD

DIGITAL SYMPOSIUM

EXPLORE, INNOVATE & GROW

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Course Fee: €95 (Includes registration and lunch)
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By attending this event delegates will better understand:

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- How Surgery to Dental laboratory digital workflows can enhance clinical outcomes and the patient experience.
- How Dental Surgery Chairside digital workflows can enhance clinical outcomes and the patient experience.
- The health economics behind Dentsply Sirona Primescan Intra Oral scanning and Chairside design and milling.

Places are limited, book your place now:

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Speakers:

Dr. Eimear O Connell

Dr Eimear O'Connell received her dental degree from the University of Edinburgh. She received her MFGDP and FFGDP from the Royal College of Surgeons London and was the first female dentist in the UK to gain her implant diploma from the Royal College of Edinburgh. She is also the first woman appointed president elect of the Association of Dental Implantology and is currently the committee member for Scotland.

Eimear has run her own private dental practice in Edinburgh since 1996. She is an international speaker and opinion leader for Dentsply Sirona and she is especially interested in digital dentistry. She has been using Cerec technology since 2008 and believes the increased success of her practice has much to do with the implementation of digital dentistry.

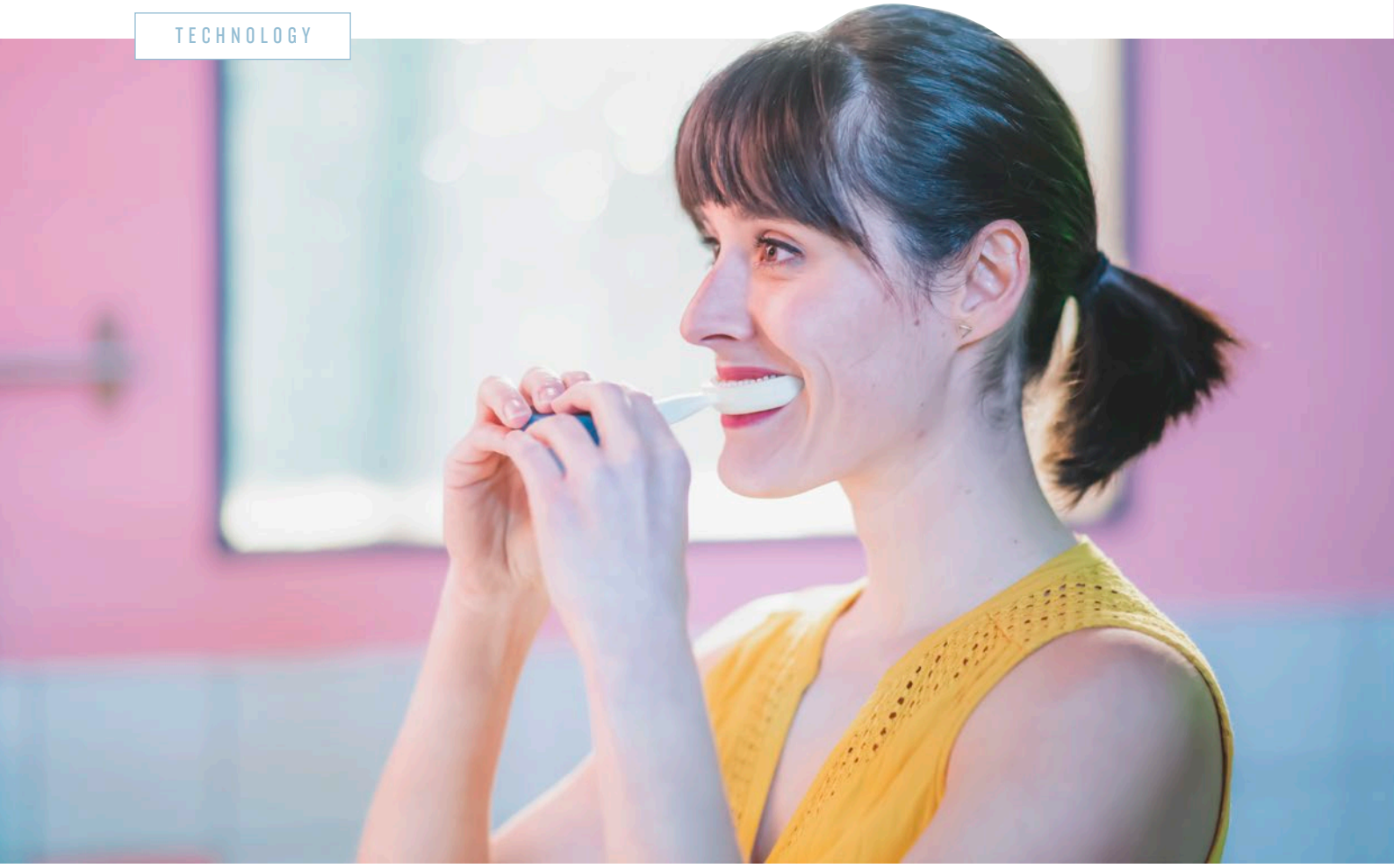
Stephen Campbell

Steve is a GDC registered dental technician with a passion for the fantastic life changing service the dental team can provide to patients.

Working with some of the most highly regarded dental surgeons in the UK, Steve and his team provide solutions for all aspects of restorative dentistry, especially implants and the new digital and CAD/CAM workflows.

The advanced work that Steve undertakes with surgical teams has struck a chord with many in the profession. This has resulted in invites to share his work at presentations and study clubs across the UK and Europe.

When not in the lab, Steve can usually be found at a dental event either learning from peers or representing one of the many dental organizations that he works with, including his current role as President of the Dental Laboratories Association.



Disrupt this!

Can start-ups challenge a £40bn industry? (Clue: don't hold your breath)

WORDS
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Disruptive innovation, said Clayton Christensen, is a process whereby a smaller company with fewer resources successfully challenges incumbents. As the incumbents focus on improving their products and services for their most demanding – and usually most profitable – customers, they exceed the needs of some segments and ignore the needs of others.

"Entrants begin by targeting those overlooked segments," observed the Harvard Business School professor, "gaining a foothold by delivering more-suitable functionality – frequently at a lower price. Incumbents, chasing higher profitability in more-demanding segments, tend not to respond vigorously. Entrants then move upmarket, delivering the performance that incumbents' mainstream customers require, while preserving the advantages that drove their early success."

From the Ford Model T, through the transistor radio, to Netflix, 'disruptive innovation' – as coined by Christensen in his book *The Innovator's Dilemma*, published in 1997 – has become an obsession for entrepreneurs driven by the potential of smaller companies to out-compete and eventually destroy their bigger competitors.

The term, he argues, is often misunderstood and misused: "Disruptive innovations are not breakthrough technologies that make good products better; rather they are innovations that make products and services more accessible and affordable, thereby making them available to a much larger population."

You could take issue with this definition – and many do – in that, for example, the iPhone contained breakthrough technologies (a touch screen with fluid scrolling and pinch-to-zoom), was more expensive than existing 'smart' phones, and yet it did disrupt – indeed, several – industries while making services more accessible and affordable at the same time; effectively challenging Christensen's mutually exclusive criteria.

Whatever your take on his definition, in the personal health sector there have been attempts at disruption and innovation; Harry's is a subscription-based men's razor that takes a tilt at the incumbents' expensive innovation (remember "introducing seven blades, because five is not enough"?), while Quip is a similarly subscription-based rival to the established players' electric toothbrush

> WHEN I SPOTTED A TOOTHBRUSH THAT CLAIMS TO CLEAN ALL YOUR TEETH IN SIX SECONDS, I IMAGINED A GLEAMING DENTAL FUTURE"
>
> JONATHAN MARGOLIS

("a product combining simplicity and accessibility of the much loved manual toothbrush with the cherry-picked guiding features that dentists recommend from an electric," say its makers).

Joining these in dental health are start-ups attempting both innovation in, and disruption of, the humble toothbrush. The prize is great; the global oral care market – comprising toothpastes, toothbrushes and accessories, mouthwashes, and other dental products – is expected to reach $60bn by 2025, up from around $40bn now*.

"I hate brushing my teeth," wrote Jonathan Margolis in the *Financial Times* last month. "Seconds into each of the prescribed two minutes, twice a day, I get bored. So, when I spotted an automatic toothbrush that claims to clean all your teeth at once in six seconds, I imagined a gleaming dental future."

Blizzident, based in Munich, has been selling a 3D-printed manual 'whole-mouth' toothbrush since 2013; a giant version of the chewable brushes you see in airport vending machines but custom-made for your mouth. However, Margolis had plunged into what turned out to be not so much a gleaming dental future, but the occasionally murky world of crowdfunded products.

Danish start-up Unobrush's blurb had testimonials from dentists, so he paid his $109 on the Indiegogo platform. Unobrush is one of many new whole-mouth toothbrushes. "I was struck by how many others were looking for a better toothbrush. Unobrush raised 70 times its target and received £2m from 30,000 backers."

Amabrush, based in Vienna, was similarly over-subscribed; it raised almost £4m from 38,000 backers on Indiegogo and 3.2m on Kickstarter. Venice-based Unico's pitch is to undercut the six-second brushing time; it claims a complete clean in three seconds. "I still live in hope that my Unobrush will materialise in August," said Margolis, "and perfect dental health in 12 seconds a day becomes reality."

Alas, for Margolis, that hope may prove to be forlorn. In June, Amabrush filed for insolvency blaming an inability of European manufacturers to fulfil the overwhelming demand and Asian manufacturers, to whom they switched, to meet quality thresholds.

"We want to assure you that we have done everything in our power to avoid this situation," a post on its website said. "We learned a lot and we'd be happy to share our experiences with all who want to realise their ideas. So do not hesitate to contact us. We encourage you not to stop supporting and believing in novel and innovative ideas that rethink the status quo and that promise to make the world a better place. We will keep fighting for our idea and project."

Meanwhile, Unico's Indiegogo page has been closed for some time (having raised £325,547), with progress stalled at the 'prototype' phase ('production' and 'shipping' remain greyed-out). But the comments page is live with more than 850 posts, including recent, plaintive, messages from disgruntled backers complaining of not having received the product or, in some cases, having received a product that disappoints or does not work.

One start-up that *Ireland's Dental* interviewed is determined to stand apart from the rest and prove doubters wrong. Based in Lyon, the makers of the Y-Brush are part of the European Union-funded accelerator EIT Health. Their brush, which claims to clean teeth in 10 seconds, is an advance on a device they developed for use in hospitals and care homes.

We asked one of the co-founders, Benjamin Cohen, about their story.

FasTeesH co-founders Christophe Cadot and Benjamin Cohen

What's your background?

I am 34 years old. I studied bioinformatics and health informatics in one of the most recognised French schools (ENS), at McGill (in Canada) and at MIT (USA). After my studies, I had multiple positions in management, as project director, team leader and operations manager in the health sector (mainly in medical devices). And then I founded FasTeesH / Y-Brush more than three years ago.

Has oral health always been of interest to you and, if so, why?

To be honest, when I was younger, I had a phobia of dentists! But I have been interested in health and biology since I was a child.

It's said that watching your younger cousins become bored brushing their teeth was an inspiration for developing the device, but what do you think drove you to actively pursue a solution?

What pushed me to move forward is for many people in the population, tooth brushing is boring, seen as a chore, because two minutes is too long. Three years ago, I met a dentist, a key opinion leader, who has helped us a lot. Yes, good tooth brushing is a real challenge. Our

> YES, IT WILL DISPLACE THE TRADITIONAL TOOTHBRUSH, BUT IT WILL TAKE A BIT OF TIME BECAUSE IT IS VERY DIFFICULT TO CHANGE HABITS"
>
> BENJAMIN COHEN

observation is that the current players are investing a lot to keep users brushing their teeth for two minutes, for example with games and applications for children. But in the end, toothbrushes have hardly changed for centuries. Our vision is to make brushing more accessible, faster, easier, and therefore more efficient.

How does the partnership with your co-founder Christophe Cadot work?

Christophe had developed sensors in another industry. On my side, I have supervised the industrialisation of IVD (in vitro diagnostics) products, such as pregnancy tests you can perform at home.

Did similar competitive products exist and, if so, why did you feel you can bring something new and different to the concept?

Our product is truly unique. There are indeed some products, which generally come from Asia, which are, like ours, in the shape of jaws. The problem is that these products use silicone tips several millimetres in diameter; too soft and too large to remove plaque. They 'massage' the teeth but have no effective plaque abrasion. On our products, we use very thin nylon fibres, thinner than a hair, like toothbrush bristles, which are really effective and able to go between teeth. We have performed many tests to prove it, and independent tests have been done on competing products.

The Y-Brush claims to clean your teeth effectively in 10 seconds

Other start-ups have attempted to develop similar products, with mixed results; why do you believe your product stands apart from these and how will you convince sceptics (both dental professionals and consumers)?

Yes, they used silicone tips that have no effectiveness – as I explained in the previous question. Our product uses the same technologies (and improved) as a standard toothbrush (sonic vibrations and soft bristles), and acts in the same way as an electric toothbrush but brushes all teeth at the same time – the top set, then the bottom.

Our product stands apart because it is effective. We are very transparent; we conducted trials with several of our customers (and they posted their feedback without review from us!), with journalists (the same), and so on. Regarding dental professionals, we have had a lot of interaction with them and very positive feedback from around the world and we are launching a special engagement programme for the profession.

Could you describe the research and development process that occurred over the three years of the product's development?

We carried out three years of R&D to obtain a product that is medically effective and well perceived by users. We mainly worked on the brush, which is very complex to manufacture, especially because it is flexible with nylon bristles. We worked on several aspects; the sizes of the brush, the user perception, the effectiveness, the design (with adults, and schools with children) and so on.

Can you provide detail about the clinical validation process that you have undertaken and whether there is a further validation process under way?

In terms of the efficacy - in vitro tests, with in vitro protocol dental researchers' use, and in vivo tests, with plaque revelator, from one brushing to a six-month period.

They were supervised by dentists trained for that. In addition, since January this year we have been selling our first product in France, under the FasTeesH brand, to hospitals, nursing homes and establishments for disabled people. This is providing a lot of feedback. And we are preparing a clinical study in France at the end of this year.

How do you intend to scale your product and business?

We have sold a lot through our website, to consumers in more than 60 countries. We will continue that. In addition to that, you'll find our products in stores from mid-2020, first in France, and then in other countries through distributors all around the world.

You were at the Consumer Electronics Show (CES) this year; what was the response?

It was great. We didn't expect it, to be honest, but we got hundreds of highly qualified contacts, and a huge press coverage with CNN, CBS, and so on.

What has been the response of the dental profession?

Great, also. You know, dentists share our point of view; that the oral health of populations is not good, and they will promote everything that could improve that.

Do you see the Y-Brush ultimately displacing the traditional toothbrush, or will it remain something which stands alongside other types of brush?

Yes, it will displace the traditional toothbrush, but it will take a bit of time because it is very difficult to change habits.

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About Y-Brush: www.tinyurl.com/y2vt4mhg

Artificial Intelligence

A vision of the future

Imagining a toothbrush that detects wider health issues and connects directly with health professionals

WORDS WILL PEAKIN

While start-ups attempt to disrupt the way we brush our teeth, the incumbents are betting on evolution rather than revolution. Egle Kiiver, a product development engineer at Procter & Gamble, points to the heritage of its Oral-B brand, founded by the American dentist Dr Robert W. Hutson. In the late 1940s, Hutson began experimenting with different designs – trying to make one soft enough to be gentle on the gums yet strong enough to effectively clean the teeth.

By 1949, Hutson discovered that using hundreds of thin nylon filaments with rounded ends could achieve the desired results. His invention has been ranked among the most significant developments in oral health of the modern era, since the advent of the bone-handled, 'hog-bristled' toothbrushes fashionable in Europe during the late 1700s. "It was the first gingiva-friendly toothbrush," said Kiiver.

For the past six months, Kiiver has been busy bringing Oral-B's most advanced toothbrush – the Genius X, that boasts artificial intelligence as a feature – to market; from its unveiling at the Mobile World Congress in Barcelona to talks across Europe, such as a meeting of the Women in AI group in Frankfurt where the spread of artificial intelligence through consumer products was debated.

However, Kiiver said that using AI to understand consumers' behaviours and needs was not the most important factor in developing the new product; the most crucial remained the insights from dentists and scientists on what can improve oral health. It was from understanding health goals that she and her colleagues could then look at what new technologies were available to meet those, such as AI.

Incorporating two sensors (an accelerometer and a gyroscope) – negating the rather clunky need of its predecessor to be paired with a smartphone camera – and an AI algorithm, the Genius X can determine where the user is brushing and how.

"It is the only brush with AI that gives real-time feedback, showing the user where he or she is brushing, tracking what the user is doing rather than telling the user what to do," said Kiiver. "The user will get results based on that. That is the advantage of this system; the user can brush like he or she usually does and then can brush the areas that still need more attention [see picture; shown in blue]."

The company's ambition for future iterations of its product extends beyond oral health. The mouth is the "gateway to health", it contends, and a toothbrush touches that twice a day. Oral-B's vision is that humans will live longer and healthier lives through dental care at home; a device that will detect wider health issues and connect directly with dental and health professionals whenever needed.

The user can brush as normal and then brush the areas that still need more attention

Currently, its Biometric Health Tracker concept is the company's idea of a 360-degree health platform, designed to improve oral and overall health. It is not a finished product, the company says; it is a vision that will enable pioneering work between dental professionals, external researchers, and Oral-B scientists alike.

"This is our vision of the future, the possibility of telling consumers if they have problems in the mouth that might affect their overall health. A change in pH level, for example, would indicate to the user that an imbalance between good and bad bacteria has developed, and the user would be advised to try to eat less sugar and more yogurt. The app would give the user daily tips and observe whether there has been an improvement or not, especially regarding the gingivae, where many problems can present and lead to other diseases.

"This is just a vision, not yet on the market, but data and scientific papers tell us that there is a relation between oral health and general health.

"I see the future as making it easier for everyone to achieve good oral health so that dentists have less restorative work and can focus on preventative care and people have the tools for expert home care."

> "THIS IS OUR VISION, THE POSSIBILITY OF TELLING CONSUMERS IF THEY HAVE PROBLEMS IN THE MOUTH THAT MIGHT AFFECT THEIR OVERALL HEALTH"
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> EGLE KIIVER

Meaningful milestone

Consultation represents the next step on the journey towards achieving a more effective system of CPD

Some dental professionals feel that CPD is little more than a tick-box exercise," says Rebecca Cooper, the General Dental Council's Head of Policy and Research. Last month, the GDC published a consultation document inviting ideas, comments, and views on the short and long-term future of professional learning and development in dentistry.

It follows the GDC's launch last year of 'Enhanced CPD', its new model of continuing professional development. Some of the changes ECPD brought included the introduction of a personal development plan (PDP) to help record CPD activity and aid further development; a change in the number of CPD hours required (100 hours for dentists, 75 hours for hygienists, therapists, clinical technicians and orthodontic therapists and 50 hours for nurses and technicians); and doing away with the need to submit non-verifiable CPD.

"While the Enhanced CPD scheme made some good progress towards increasing professional ownership of CPD and placing greater emphasis on reflection and planning," adds Rebecca, "we know a more supportive model of learning can be achieved to provide dental professionals with the information and tools they need to meet and maintain high professional standards and quality patient care.

"Our proposals look at how we might move to a system

> "WE KNOW A MORE SUPPORTIVE MODEL OF LEARNING CAN BE ACHIEVED TO MEET AND MAINTAIN HIGH STANDARDS AND QUALITY PATIENT CARE"
>
> REBECCA COOPER

that is flexible and responsive for the full range of dental professionals and where professionals can increasingly take responsibility for their own development, without the need for heavy-handed enforcement. This discussion document represents a significant milestone in achieving this goal and we really want to hear from as many people as possible about where lifelong learning should go from here."

The discussion document is presented in three parts: a future model for lifelong-learning which seeks views on a portfolio model and the merits of continuing with set CPD hour requirements; CPD practices, and how professionals can be encouraged to take up more high-value activities, such as peer learning and reflection; and informing CPD choices, which asks about the insights and intelligence dental professionals refer to when selecting learning activities and how these can be improved and promoted.

The publication represents the next step on the GDC's journey towards achieving a more effective system of CPD. That journey began with commitments made in the regulator's 2017 publication *Shifting the Balance* and the introduction of the Enhanced CPD scheme last year. Since then, this journey has continued with the gathering of further information and evidence through stakeholder feedback, a systematic literature review on CPD and, most recently, through workshops with professional associations, educators and other regulators which took place earlier this year.

After building a robust base of evidence, the GDC says it wants explore ideas for developing the CPD scheme with dental professionals and stakeholders and that it is "opening a conversation" about what meaningful CPD is, how it can be achieved, and what the obstacles might be that prevent dental professionals from accessing and undertaking it.

The literature review synthesised relevant articles and outlined the approach other professionals are taking. It provided the GDC with evidence, which can support its development of a more qualitative approach to the delivery and monitoring of CPD for the dental workforce. The aim was to inform and strengthen GDC policy development for dental CPD that would promote registrants' sense of ownership and pride in their continuing educational achievements and in turn improve engagement between the regulator and the dental workforce.

It concluded that aspects of qualitative-based models which could form part of an outcomes-focused model for dental UK professionals include: emphasis on reflection and reflective practice, active learning, portfolios, peer (and mentor) interaction and feedback; development of online, user-friendly tools, enabling registration of required evidence; a well-designed change and implementation process; reinforcement of close engagement of registrants with regulators through easily accessible communication channels; quality-assurance mechanisms embedded in the model, valuable for both regulators and registrants.

"If the aspiration is to create motivation across all registrants to actively pursue meaningful, relevant CPD activities," said the review, "then of course the approach to CPD should promote the concept of a responsible professional, who takes pride in keeping up to date and enhancing their clinical and professional skills and sharing their experience with others."

REFERENCES

The document can be read here: www.tinyurl.com/yyz8jeo5

Responses and views can be submitted until 3 October here www.tinyurl.com/yy8f6hfr

Examination of the truth

It isn't enough to think 'I did that OK'; professionals need to give the process of reflection authority and value

WORDS
WILL PEAKIN

Earlier this year, the General Dental Council and eight other healthcare regulators published a joint statement on the importance and benefits of being a reflective practitioner. The organisations' chief executives signed a joint statement* which outlined the processes and advantages of good reflective practice for individuals and teams.

Reflection is the process whereby healthcare professionals assess their professional experiences – both positive and where improvements may be needed – recording and documenting insight to aid their learning and identify opportunities to improve. Reflective practice allows an individual to continually improve the quality of care they provide and gives multi-disciplinary teams the opportunity to reflect and discuss openly and honestly.

The statement made clear that teams should be encouraged to make time for reflection, as a way of aiding development, improving wellbeing and deepening professional commitment. Chief executives of nine regulators – the General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, the Nursing and Midwifery Council and the Pharmaceutical Society of Northern Ireland – have all signed the statement.

"Reflection plays an important role in healthcare," said Ian Brack, Chief Executive and Registrar of the GDC. "It brings significant benefits to patients by fostering improvements in practices and assures the public that professionals are learning from the challenges they encounter – and seeking to improve.

"Our recent research on CPD highlighted the importance of multi-professional teams coming together regularly to reflect when things go wrong and when things go right, and this is one of the things that we are going to be seeking views about when we consult on the future of lifelong learning for dental professionals in the early part of this summer" [See Meaningful milestone, p26]

The joint statement by the regulators reinforces the view that reflection is a key element of development. It also makes clear that patient confidentiality is vital, and that registrants will never be asked to provide their personal reflective notes to investigate a concern about them. Guidance is given on how to get the most out of reflective practice, including having a systematic and structured approach with proactive and willing participants. It makes clear that any experience, positive or negative and however small – perhaps a conversation with a colleague – can generate meaningful insight and learning. Multi-disciplinary and professional team reflection is viewed as an excellent way to develop ideas and improve practice.

How can reflection help dental professionals?

As well as reinforcing how reflection can help dental professionals to gain insight into their whole practice, the statement highlights the direct impact it can have on improving services and patient care. It endorses the value of dental teams reflecting as a group and in multi-professional settings, to help develop ideas that can bring about positive change in practice. As part of this, it makes it clear that employers should encourage their teams to make time for reflection as a way of aiding development, improving wellbeing and deepening professional commitment.

Reflection is now common practice among dental professionals and will help to foster improvements in your dental practice and services. It can demonstrate how patient feedback and complaints are listened to, and acted upon, in the dental practice setting, as well as assure patients that the dental team is continuously learning. It encourages professionals to "remember to reflect on things that go well, alongside things that don't go to plan".

Jessica Rothnie, a policy manager at the GDC, who was involved in the roll-out of the Enhanced CPD scheme and in the formulation of the statement on reflective practice, acknowledged that there was a need for more guidance around what reflective practice should cover and what form it should take.

"Professionals need more guidance and help on how they reflect and how they do it effectively," said Jessica. "Absolutely, I think there is a gap there and part of the CPD consultation is building up more information around the concept."

As part of that process Janet Hayes-Hall, the GDC's Clinical Dental Adviser, is publishing a series of blogs over the summer. "As the recent publication of the joint statement attests, health regulators now consider that reflection is an essential aspect of clinical practice," said Janet. "For dental professionals, it might feel as though 'reflection' has worked its

The reflective process should help professionals to remember and embed new practice, learning or behaviours into their clinical or practice repertoire=

way into our lexicon in recent years as a relatively new concept."

But, she added, reflective practice has a long history. John Dewey, a philosopher and educator addressed this issue as far back as the late 1890s. He described reflection as "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends". While there have been many interpretations and variations in the wording since, Janet believes that his first considerations remain the core to reflective practice.

She points to the academic author and editor Gillie Bolton who observed: "I have come to realise .... that reflection is not a cosy process of quiet contemplation, it is an active, dynamic, often threatening process which demands total involvement of self and a commitment to action. In reflective practice there can be nowhere to hide."

Janet Hayes-Hall's interpretation is that reflection is expected to support deep, rather than strategic or superficial learning. This means that the reflective process should help professionals to remember and embed new practice, learning or behaviours into their clinical or practice repertoire.

"However, in my experience with many dental professionals, reflection is often considered to be a 'cosy' process such as thinking that a procedure went well, or 'those crowns looked great'. I have also found that dental professionals are unclear as to what they 'should' be doing to reflect effectively. For example, when I have asked a dentist for a piece of reflective writing I have been presented with a formal essay or cut and paste items from a textbook or journal document. But, while it's good to see there is genuine enthusiasm for the subject matter, I am often disappointed that the real learning hasn't been demonstrated. Ultimately, the reflective process has been missed.

"Perhaps this is because when asked to reflect in a more formal sense, dental professionals get stuck. I suspect a huge number of dental professionals actually 'reflect in action' on a regular basis, a phrase first introduced by Schon in 1991. In other words, we think on the go: we may determine that we will use a different product next time because the one we are using hasn't produced the appropriate colour, fit or shade, or we will use a different technique because of something learnt on a course. These actions or thoughts may be reflective in nature, but is this what reflection is really all about?

"Looking back on Dewey's definition, he states that reflection is the 'active persistent and careful examination of the truth and the facts that surround it'. I think that 'active' is the key word here. Active means we should engage with the process, that we need to do something. It isn't really enough to just think 'Oh that went well' or 'I did that ok'. We need to do something more to give that process of reflection some authority and value."

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*https://www.gdc-uk.org/professionals/cpd/reflective-practice

Other useful links:

https://www.gdc-uk.org/about/what-we-do/research

https://www.gdc-uk.org/professionals/ftp-prof/learning

https://www.gdc-uk.org/about/what-we-do/consultations

What the literature says about reflective practice

CPD and reflective practice are interrelated: reflection can enhance the benefit of CPD, and reflective approaches to practice can be promoted by CPD. Reflective practice is prominent within the most current CPD schemes and revalidation processes (UK solicitors, UK engineers, UK pharmacists, Ontario pharmacists and others).

Key points are:

- It is argued that the ability to reflect is not inherent and practitioners may need to be educated on how to reflect. This ability increases over time and with practice.
- The impact of reflection-on-practice is enhanced when it is undertaken willingly and shared with colleagues. Peer learning, group learning, mentoring and appraisal enhance the professional's ability to reflect on their practice.
- Portfolios can be used to record learning experiences and promote reflection. Portfolio-based learning is used, for example, with UK doctors and Ontario pharmacists. Questions remain as to whether current CPD systems really foster reflective practitioners. The portfolios and other reflective exercises included within the CPD schemes have to be real opportunities for practice improvement and not just a 'box to tick' exercise within the CPD scheme.

Source: A Review of the Literature on Continuing Professional Development (CPD)
Executive Summary (commissioned by the GDC) January 2019.

"I HAVE COME TO REALISE THAT REFLECTION IS NOT A COSY PROCESS OF QUIET CONTEMPLATION"

GILLIE BOLTON

RCSI ASM 2019

From cradle to grave

The changing challenges and demands of oral surgery throughout a patient's life will be put under the spotlight at this year's RCSI Annual Scientific Meeting

"I didn't think at the time that we were planning this, we'd still be in the throes of Brexit!" Dr John Marley, Dean of the Faculty of Dentistry at the Royal College of Surgeons in Ireland (RCSI), is musing on the timing – 1-2 November – of its Annual Scientific Meeting (ASM); the days immediately following the United Kingdom's scheduled exit from the European Union.

This will be Marley's last ASM as Dean, but it will also be a 'first'; the first time that the Association of British Academic Oral & Maxillofacial Surgeons (ABAOMS), the British Association of Oral Surgeons (BAOS), and the Irish Association of Oral Surgeons (IAOS) have gathered together.

The meeting is titled 'Challenges to Oral Surgery in Dental Practice in the 21st Century: From the Cradle to the Grave'. "I wanted to chart that journey, from paediatric, to young adult, adult, older adult and elderly adult," he said, "looking at various aspects of dental healthcare as they apply to those groups during a time of significant change for the profession and particularly for Oral Surgery delivery and especially in light of the recently published National Oral Health Policy for Ireland. As always, the aim of the scientific programme is to provide the dental team with evidence-based, relevant and practical information for their day-to-day practice."

Dr Marley added: "For the child patient we will tackle subjects as diverse as the future of oral surgery delivery post-Brexit and in the context of the National Oral Health Policy, appropriate CBCT use in paediatric patients and tomorrow's antibiotics for today's children.

"For the young adult we will explore early identification and implications of dependency, resilience in the young surgeon and managing the increasing demands and expectations of the younger generation of patients for oro-facial cosmetic surgery, as well as dispelling the myths around the rationale for orthognathic surgery.

"In the adult, we will explore

WORDS
WILL PEAKIN

what is new in TMD management, managing risk in oral surgery practice and adoption of augmentative surgery versus alternate methods of enhancing bone and soft tissues prior to dental implants. We will also be looking at how and why head and neck cancer patients frequently develop debilitating pain and how to manage it in our surgeries and the new evidence base for prophylactic dental extractions in patients who are about to receive or receiving radio/chemotherapy.

"With the aging patient we will look at the challenges of identification and consent of patients with dementia, polypharmacy in the elderly and its implications for oral surgery and cutting-edge science of managing impaired wound repair in the older patient."

Among the speakers are:

Michael Donaldson, Head of Dental Services at Northern Ireland's Health and Social Care Board, who as part of his presentation will be reflecting on the oral health policy launched earlier this year by the Irish Government;

Andrew Bolas, lecturer in dental radiology at Dublin Dental University Hospital, who will look at the growing use of dental cone beam computed tomography (CT) in the context of its use with children;

Dave Thomas, professor and honorary consultant in oral and maxillofacial surgery at Cardiff University's School of Dentistry, who will report on the work of the School's Advanced Therapies Group in developing 'nanomedicines' – novel anti-infective approaches from nature, to treat life-threatening infections – and, in a second presentation, will look at the challenges of impaired wound healing in the elderly and compromised patient;

Dr Angela Jones; clinical psychologist and practicing dentist who will explore the role of the dentist in identifying addiction and misues of recreational drugs in the young adult;

Natasha Devon, the writer and campaigner who has dedicated her life to promoting positive mental health, body image, gender and social equality, will explore the changing demographics of demand for cosmetic surgery;

Wendy Turner, a specialist periodontist, with extensive experience in teaching both undergraduate and graduate dental students, will be speaking to the theme: Young dentists: The snow-flake generation or future leaders?;

Brian Schmidt, professor of oral and maxillofacial surgery at New York University and Director of the Bluestone Centre for Clinical Research, will be addressing the scientific basis for pain management in the post treatment head and neck cancer patient.

The venue for this year's lectures will be the RCSI, St Stephen's Green.

About

ABAOMS: Established in 2004 to support the dental schools and individuals in their drive to increase the international competitiveness of the research, education and clinical practice of oral and maxillofacial surgery. It is the representative body of academic oral and maxillofacial surgery in the UK and all of the UK and Irish dental schools are represented.

BAOS: Represents all practitioners with a special interest in oral surgery in both primary and secondary care. The Association's aims are to promote the development of specialist oral surgery practice and address issues relating to NHS and private practice, training, clinical governance and post-specialist training.

IAOS: Established in 2014 to promote the specialty of oral surgery within the dental community and within the public in general. Its membership is comprised of specialist and trainee oral surgeons.

Looking ahead to 2020

The Faculty of Dentistry RCSI will host a Post-Primary Careers Day event on Saturday, 18 January 2020. The event is aimed at transition year students, along with 5th & 6th years, who are interested in a career in dentistry.

While the Royal College of Surgeons in Ireland does not presently have a dental school, Dr John Marley, Dean of the Faculty said: "We recognise deeply our responsibility for public engagement to attract and retain a new generation of dentists." The Faculty regards the event as an extremely exciting and important opportunity to raise the awareness of dentistry.

For students that travel to the RCSI on the day, there will be presentations from senior academic staff from all three Dental Schools on the island of Ireland - Trinity College Dublin, University College Cork and Queens University Belfast. In addition, there will be speakers from different sectors of dentistry along with opportunities to meet students and explore their experience of dentistry.

Following the formal presentations, delegates can meet the admissions teams from each dental school, along with dental student representatives. There will also be interactive stations and students will be able to meet and ask questions of dentists who practice in various fields.

"In this unique event we are working with the three dental schools on the island of Ireland. We're hosting this exciting event to reach out to, attract and help retain a new generation of dentists," said Dr John Marley. "We want to raise the awareness of dentistry on the island of Ireland. Attendees can expect fantastic presentations from senior academic staff from all three dental schools describing what they can offer and specialists in the field of dentistry to help students map our possible future careers.

"Students can also experience first hand what goes on in the various specialist fields of dentistry at interactive stations. For those that can be there on the day we will be streaming selected aspects of the conference".

Interested pupils should speak to their Career Guidance Counsellor or Teacher.

Full details including registration information has been sent to all schools on the island of Ireland. Further details can also be obtained by contacting the Faculty of Dentistry office: facdentistry@rcsi.ie

For full programme details visit asm2019.ie or alternatively contact the Faculty of Dentistry office: facdentistry@rcsi.ie

"THE AIM IS TO PROVIDE THE DENTAL TEAM WITH EVIDENCE-BASED, RELEVANT AND PRACTICAL INFORMATION FOR THEIR DAY-TO-DAY PRACTICE"

DR JOHN MARLEY

A vision for oral health in Northern Ireland

Stakeholder event this autumn aims to be a watershed moment for policy

WORDS
WILL PEAKIN

More than 4,700 children were admitted to hospital for tooth extractions in Northern Ireland last year. From 2017 to 2018, dentists extracted 23,035 teeth, of which 89% were baby teeth; taken out due to decay. By the age of 15 just under a fifth (19%) of children in Northern Ireland can be considered to have good oral health overall.

While there have been headline improvements in the oral health of young people across the UK, inequalities remain "stark and persistent", according to a briefing paper prepared by BDA Northern Ireland ahead of what representatives hope will be a "watershed" summit, to be held at Stormont on 17 October.

For some time, Northern Ireland has been at the bottom of the league table when it comes to children's oral health outcomes in the UK, with 40% of five-year-olds showing signs of decay, compared with 25% in England. There are also distinct variations in oral health outcomes depending on socio-economic background; children from lower income families are much more likely to have oral disease than other children of the same age.

According to the latest Children's Dental Health Survey, more than a fifth (21%) of five-year-olds eligible for free school meals had severe or extensive tooth decay, compared with 11% of other children of the same age.

In 15-year-olds, more than a quarter (26%) of the 15-year-olds eligible for free school meals have severe or extensive decay; more than twice as many as their peers who are not eligible (12%). These figures, says the briefing paper, suggest the gap between oral health of children from richer and poorer backgrounds widens as they grow older.

Children from lower income families are also much more likely to have poorer diets and consume more sugary drinks; in Northern Ireland almost a quarter (24%) of children on free school meals drink sugary drinks four or more times a day, compared with just 1 in 10 (10%) of children who are not eligible for free school meals.

"Poor oral health affects not only children's physical health, but also their overall wellbeing, confidence, mental health and development," observed Tristen Kelso, the BDA's Northern Ireland Director. "Problems with teeth can impact on a child's ability to sleep, eat, speak, play and socialise with other children, as well as their school readiness. This summit is designed to not just highlight the work we need to do, but to start to come up with a new, more ambitious, positive vision for oral health in Northern Ireland – in collaboration with key stakeholders.

"Northern Ireland faces incredible challenges when it comes to oral health, particularly for our most vulnerable cohorts at both ends of the age spectrum. Tackling these challenges requires a new vision, one that is ambitious and underpinned by a policy framework that is suitably resourced."

Last month, SDLP Health Spokesperson Mark H Durkan, expressed concerns following disclosure of 800 GP referrals for patients at high risk of developing Type 2 Diabetes between March and May of this year.

Durkan has previously pressed the Department of Health to ring-fence funds from the Soft Drink Industry Levy (SDIL) to address related health issues- including Type 2 Diabetes, obesity and improving dental hygiene.

The MLA for Foyle commented: "The NI Block Grant has benefitted from approximately £12million of Soft Drink Industry Level funding in 2019/2020. Since the introduction of the tax in 2016 I have made consist calls for

> "WE NEED TO POOL ALL OF OUR RESOURCES TO ADDRESS THE MASSIVE PUBLIC HEALTH CHALLENGES WE FACE TODAY"
>
> CAROLE LAPPIN

this money to be ring-fenced.

"In the prolonged absence of Stormont, it is disappointing that the department has failed to direct the entire revenue generated by this levy toward targeting obesity, Type 2 Diabetes and dental hygiene. Funding from the plastic bag levy, brought in during my time as Environment Minister, was made specifically available to environmental projects- therefore this approach is not only doable but necessary.

"It is axiomatic that the failure to do so has seen the North spiral into an obesity crisis in the interim and most alarmingly figures released this year show that 17% of children here are overweight. When targeted early, three-in-five cases of type 2 diabetes can be prevented or delayed yet the lack of action has undoubtedly aided the exponential rise in diagnoses.

"The inability to invest this money in preventative healthcare, costs our health service millions of pounds through needless lowering of quality of life and in some cases the rising number of related deaths. We must stop making short-sighted decisions when it comes to health."

He continued: "I welcome assurances from the department that collaborative framework is currently underway to address these health issues. Yet it is lamentable that these crucial preventative healthcare measures have not been implemented sooner."

Speakers at the summit include Caroline Lappin, CDS Clinical Director at the South Eastern Trust and Chair of the BDA's Northern Ireland Council; Gerry McKenna from Queen's University Belfast, and Chair of BDA NI's Hospitals Group; Simon Reid, Chief Dental Officer at DoH, and Michael Donaldson, Head of Dental Services at the Health and Social Care Board.

Last December, the Chairs of BDA Northern Ireland's three committees, wrote to the Department of Health expressing concern that the £12.3m raised from the Soft Drinks Industry Levy would not be spent on improving children's dental health because, in the words of the Chief Medical Officer, there was "no mechanism in place to hypothecate the tax".

Tristen Kelso added: "Few could argue that we don't have pressing oral health needs in Northern Ireland, yet we have an Oral Health Strategy that dates back to 2007 and has never been formally evaluated.

"As a result of this policy vacuum, there is a need to recouple oral health with wider public health policy, and the important contribution dentists can make in this regard.

"With the right level of commitment and collaboration, these difficulties are not insurmountable"

Looking ahead to the Stormont event, Lappin said: "The research that points to a correlation between oral health and overall health is growing by the day. We need to pool all of our resources into addressing the massive public health challenges we face."

Teeth extracted from 2017 to 2018

23,035

of which

89%

were baby teeth

4,700+

children were admitted to hospital for tooth extractions in Northern Ireland last year

40% of 5 year olds showing signs of tooth decay

The anxious patient:

Empathy, planning and a team-approach

Ilyaas Rehman, BDS (Glas)

Background

A 41-year-old anxious female patient attended the practice for an examination in February 2019; the first time in nine years. She complained of a broken tooth in the lower right side, which was presently asymptomatic but felt sharp to the tongue. In addition to this, the patient was aware of the poor condition of her remaining dentition, stating that she was unable to eat or socialise confidently. She alerted us to using Superglue to hold her remaining crowns in, and teeth together.

The patient was now keen to try to rehabilitate her dentition and therefore the motivating factors for her attendance were:

1. Embarrassment: unable to socialise confidently, unable to smile without covering her mouth.

2. Function: unable to eat hard or crunchy foods, insufficient posterior teeth to chew with.

3. Poor quality of life.

Medical, Dental and Social History

The patient informed us of having multiple sclerosis and hypertension, which were being controlled by Interferon and Amlodipine respectively. She reported previous asthma, for which medication was no longer required. She also reported taking Fluoxetine, Lansoprazole, Thyroxine and Dihydrocodeine.

The patient could not remember the last time she attended the dentist, however computer records confirmed this to be nine years ago. She reported having several bad experiences in the past which have amounted to severe general dental anxiety. She brushed twice daily with a manual toothbrush and was not presently using any interdental aids or mouthwashes.

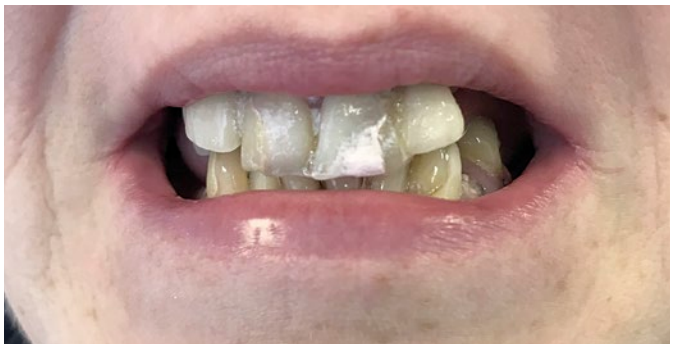
She worked full-time as a veterinary nurse. She quit smoking 6-7 years ago after smoking roughly twenty cigarettes a day for twenty years (twenty pack years) and reported zero alcohol consumption.

Examination

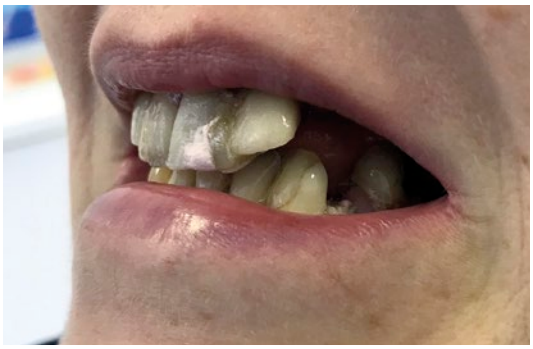
No abnormalities were detected on extra-oral examination.

Intra-orally, the patient's soft tissues showed no abnormalities. The patient was partially dentate with a heavily restored remaining dentition, including failing crowns. The occlusal relationship was class 1 and there was lack of posterior occlusal support. Oral hygiene was poor, with evidence of generalised gingivitis and plaque. Despite this, the present BPE scores did not exceed 2s. A fractured 44 amalgam was observed, and a temporary filling was placed here prior to further radiographic and clinical assessment.

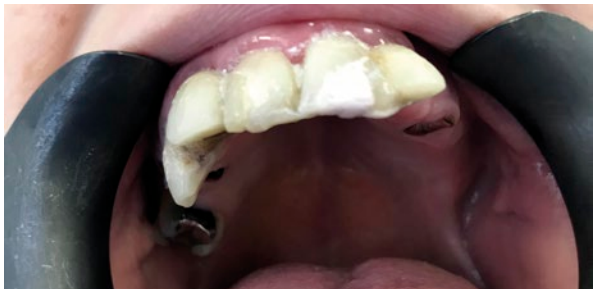
There was also evidence of excess material across the upper anterior teeth, which the patient informed us of being Superglue to hold in the crowns. Application of firm digit pressure to the upper anterior teeth caused mobility of 2-3mm of the entire sextant. Caries was recorded clinically in teeth 13, 11, 21, 44, 31 and 33. There was also



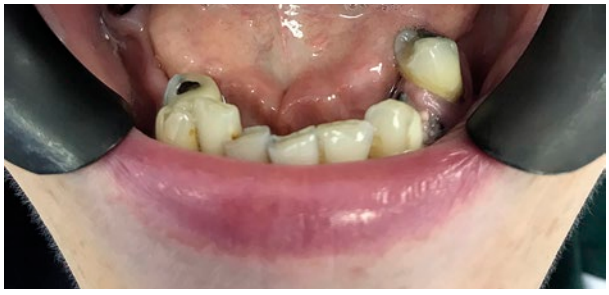
E/O Frontal View



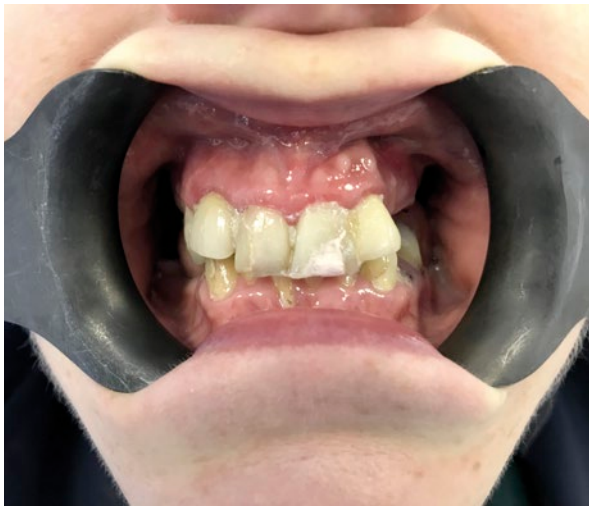
E/O Lateral View



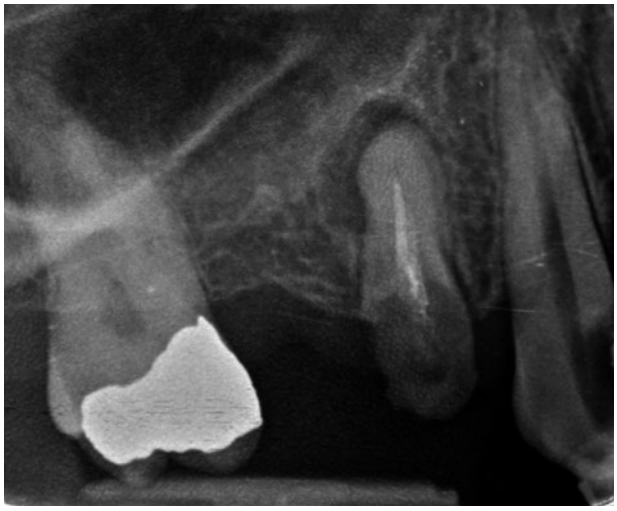
I/O Maxillary View



I/O Mandibular View



E/O Retracted Frontal View



Periapical Upper Right

presence of several retained roots.

Due to the clinical findings, periapical radiographs and clinical photographs were taken.

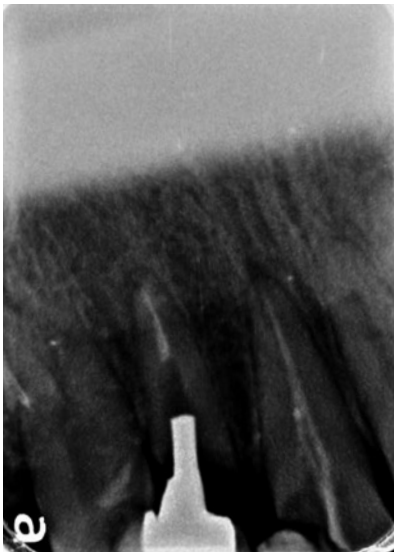
A list of diagnoses was subsequently established:

- Generalised gingivitis.
- Generalised Periodontitis Stage II Grade B – currently stable – risk(s): ex-smoker.
- Primary caries: 13, 31.
- Secondary caries: 11, 21, 44, 33.
- Defective restorations: UR2, UL2.
- UR1 previously RCT with asymptomatic PAP.
- UR4 retained root, previously RCT with asymptomatic PAP.
- LR3 vertical fracture, previously RCT with asymptomatic PAP.
- UL4 retained root with asymptomatic PAP.

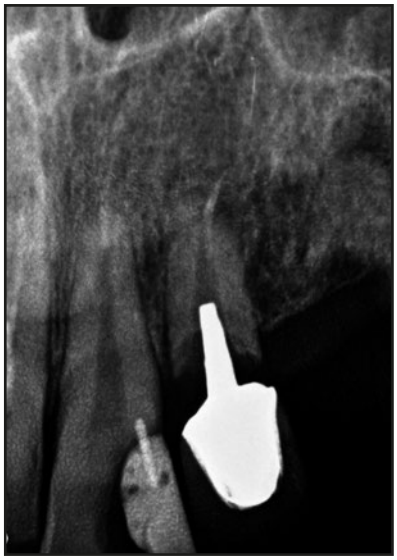
Treatment Options

Aims of treatment were to restore health, function and aesthetics. Four possible avenues were discussed:

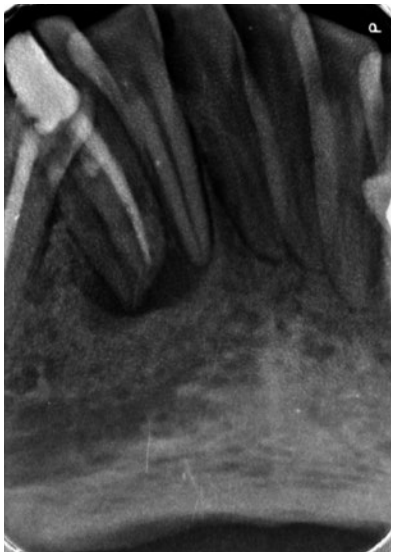
1. Deconstruing the upper anterior segment, reassess and potentially restore: Re-RCT 11 12 22 and restore with post-core crowns.
   – Caries removal and restoration Extraction of retained roots and LR3.
   – Provision of upper and lower immediate partial dentures.
2. Extraction of all teeth of poor prognosis – 13, 12, 11, 21, 22 and retained roots. Provision of immediate upper and lower partial dentures
   – Caries removal and restoration.
3. Extraction of all teeth of poor prognosis, implant approach to restoring gaps, caries removal and restoration.
4. Referral to specialist service (NHS/ Private).



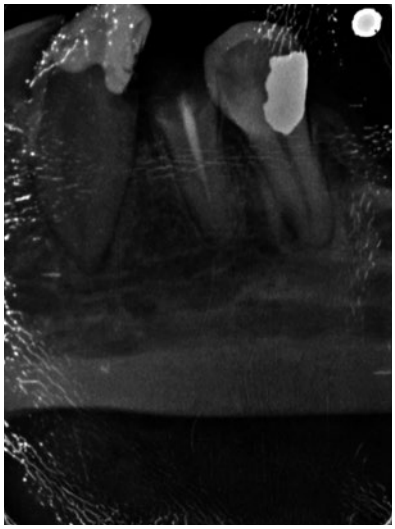
Periapical Upper Anterior i (G2 coned off)



Periapical Upper Anterior ii



Periapical Lower Anterior



Periapical Lower Left

Each option was discussed in detail. Following this, the patient initially opted to try option one, despite understanding the plethora of risks attached and the poor prognosis of the remaining teeth. However, further probing revealed this was due to a severe anxiety of extractions.

Appropriate evidence-based anxiety management techniques were discussed, including desensitisation, acclimatisation and in-house IV sedation. The patient subsequently made an informed decision to proceed with option two. All items of treatment were to be carried out under the NHS, excluding the LR4 due to lack of mechanical retention for amalgam.

Treatment

A staged treatment plan was proposed as follows:

1. Immediate
- Temporisation of fractured LR4.

2. Initial
- Hygiene Phase Therapy: OHI (tipps), diet advice, supragingival scale.
- Extractions under IVS: 13, 12, 11, 21, 22, 43 and retained roots 14, 24, 47, 34.
- Provision of immediate upper and lower partial acrylic dentures.
- Caries removal and restoration: LR4, LL1, LL3.

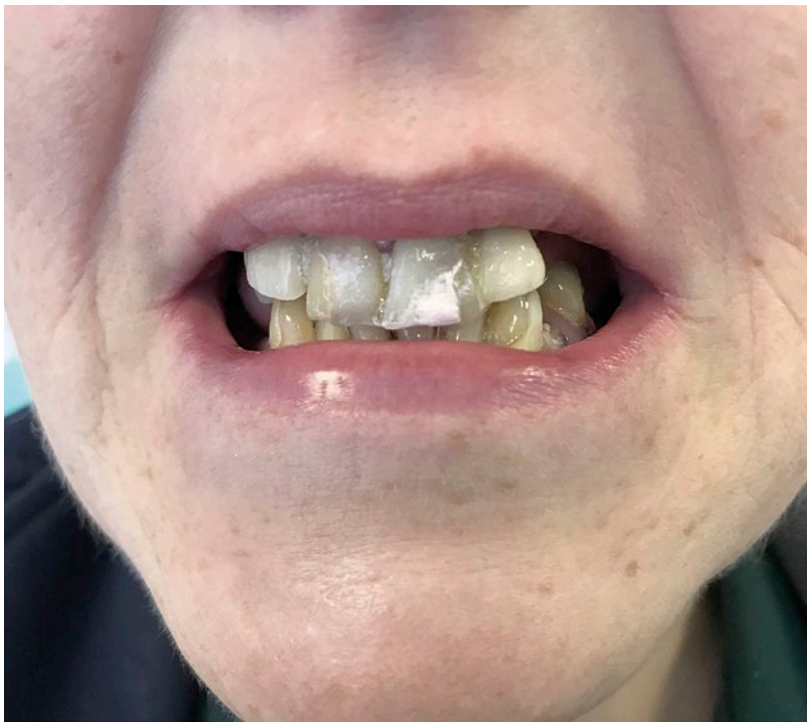
3. Re-evaluation.

4. Reconstruction
- Provision of new upper and lower partial dentures.

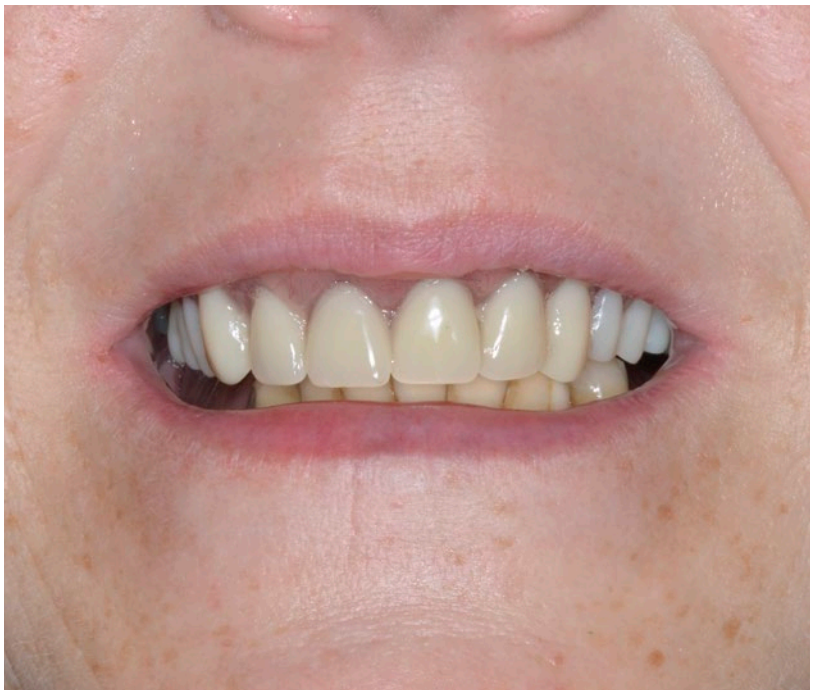
5. Maintenance.

The patient showed exceptional motivation to overcome anxiety and strive towards a healthier oral environment. There were two key problems encountered with treatment. Firstly, extraction of 47, 43 and 34 required a surgical approach. This was carried out in-house on the same appointment with assistance and therefore was rectified accordingly. Secondly, the patient found that she was unable to tolerate the lower denture. However, rather than this being due to the lower denture fitting poorly and uncomfortably, the patient felt she would prefer to firstly get accustomed to the upper denture alone. In effect, the patient was functioning with a modified shortened dental arch.

Subsequent to completion of the initial treatment, the patient returned with irreversible pulpitis associated with 35 and root canal therapy was carried out.



Pre-operative



Post operative

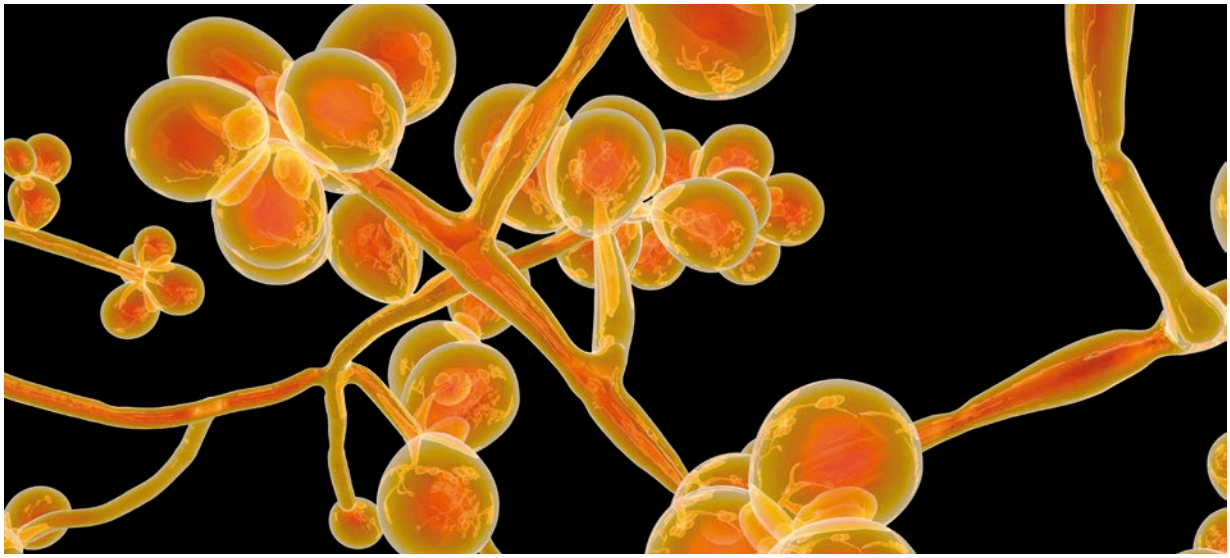
Pre-operative Conclusion

The patient expressed thorough delight with the result of the treatment carried out and has, as a result, developed trust with the practice and treatment providers. She is now able to interact and socialise confidently, smile freely and eat healthily.

Though arguably no part of this treatment plan is especially complex, this case has been a thorough learning experience in the management of an anxious patient. With the assistance of senior colleagues, I was able to provide the patient with an outcome that we are both very pleased with. I believe that, as a result of implementing basic principles successfully from the onset, the patient has regained her trust in the profession.

The risk of anti-fungal resistance in dentistry: lessons from a Japanese fungus

Alex Farrow-Hamblen



Globally since 2009, Candida auris, a fungal species closely related to Candida albicans, has been responsible for a number of drug-resistant hospital-acquired fungal infections. Though C. auris is yet to be isolated from the human oral microbiome, ten years since its discovery in Japan, what can the UK dental profession learn about antimicrobial stewardship and the prescription of anti-fungal agents from this lesser-known 'superbug'?

Over my last four years as a dental student, the importance of antimicrobial stewardship and best practise when prescribing antimicrobial agents has been a key focus of my clinical training. Where antimicrobial resistance remains a growing threat to public health in the UK[1], the Scottish Dental Clinical Effectiveness Programme's (SDCEP) clinical guidance document: *Drug Prescribing for Dentistry*[2], is a valuable resource to General Dental Practitioners (GDPs) in protecting against the indiscriminate use of antibiotics in Primary Dental Care. Despite this guidance – and the fact that the overprescription of broad-spectrum antibiotics can lead to a reduction in therapeutic inefficacy[3] – the similar threat of anti-fungal drug resistance in dentistry is less reported within dental literature.

Amongst the many microbial species that colonise the oral cavity, Candida albicans is the most common of the fungal species[4]. Though often co-existing as a harmless commensal microbe, acute and chronic episodes of immunosuppression can lead to candida overgrowth and symptoms of opportunistic oral or systemic candidiasis[v]. In such cases, GDPs may quickly reach for the prescription pad, prescribing an anti-fungal agent such as the polyene nystatin (oral use) or the azoles miconazole (topical use) or fluconazole (oral & systemic use)[5]. However, the overuse of antifungal agents, like antibiotics, can similarly confer multi-drug resistance[6,7]. As resistant strains of Candida can have an adverse effects on respiratory and gastrointestinal health upon colonisation of their respective epithelia[8,9,10], could drug-resistant strains of Candida, such as C. auris, pose a threat to the health of susceptible patients in general dental practice?

To date, Candida auris is yet to be established as part the human oral microbiome, first isolated from the ear of an elderly patient in Tokyo Metropolitan Geriatric Hospital (Japan) in 2009[11,12]. A close derivative of Candida albicans, in the ten years since its discovery, C. auris has been identified as a global cause of numerous life-threatening cases of fungaemia in hospital-bound patients[11,12]; the strain also linked to several hospital infections in the UK[13]. Interestingly, as the overuse of azole antifungals in the East Asian agricultural industry and global medical setting have been cited as a likely reason for the 'success' of this multi-drug resistant fungus[11,12], similar resistant fungal strains may also develop if anti-fungal agents are overprescribed, or used prophylactically, in dentistry; particularly as the use of azoles in the UK, two of the three licensed anti-fungals in the *Dental Practitioners' Formulary*[5], appear to have grown over recent years[14].

So, what lessons can the dental profession learn from the emergence of C. auris as a nosocomial (hospital-acquired) infections in recent years? Firstly, ensuring that clinical audit,

USEFUL RESOURCES

- Scottish Dental Clinical Effectiveness programme – Drug Prescribing for Dentistry Dental Clinical Guidance app
- Scottish Antimicrobial Prescribing Group – Antimicrobial companion app
- National Institute of Health Care Excellence Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use (2015)

ABOUT

Alex Farrow-Hamblen is a final year student at Carlisle Dental Education Centre / School of Medicine & Dentistry, University of Central Lancashire.

addressing the appropriateness of antimicrobial prescribing, includes antifungals as well as antibiotics should be encouraged; assessing how local prescribing habits match SDCEP guidance[2] in the hope of identifying and minimising anti-fungal overprescription. Similarly, as advocated when treating oral bacterial infections, local measures should always be considered before prescribing any antimicrobial agent. For example, as described by SDCEP[2], in the case of the candidal infection denture stomatitis, establishing the likely cause of fungal overgrowth and remedying this, e.g. educating patients in the improvement of denture hygiene, should be a first-line approach when managing oral fungal infections.

Arguably, the suggestions above should already form part of everyday clinical practice. However, a difficulty faced in promoting antimicrobial stewardship within NHS Dentistry is ensuring that GDPs are best placed to make such changes, i.e. have access to necessary tools and funds to implement recommendations. For example, the National Institute of Clinical Healthcare Excellence's (NICE) guidance [NG15]: *Antimicrobial stewardship: systems and processes for effective antimicrobial medicine*[15], suggests that in the case of persistent antimicrobial infections, oral microbiological sampling techniques should be encouraged to improve the specificity of diagnoses and thus the appropriateness of an antimicrobial prescription. Though an example of active antimicrobial stewardship that could be useful in identifying drug-resistant fungal strains, the likely costs, need for additional training, the lag time between diagnosis and prescription and the storage and transport of microbiological samples to and from a clinical laboratory are potential barriers to such a programme.

In the meantime, it seems prudent that dental advisory committees and dental schools should continue to advocate best prescription practice, emphasising the more inclusive term of 'antimicrobial resistance' over 'antibiotic resistance' in guidance documents and teaching; ensuring that GDPs and students are well aware that all modes of antimicrobial agents, available for prescription, are sensitive to drug resistance. Although available for free, increasing the 'appeal' of NICE's antimicrobial prescribing guidance[15] may be of benefit in increasing both readership and compliance with such guidance.

It is also an opportunity for verifiable CPD, which is especially important as antimicrobial prescribing is not yet recognised by the General Dental Council (GDC) as one of their 'highly recommended CPD topics'[17]. It may also lead to making such information more 'user-friendly' as part of an app or interactive resource for GDPs, the latter pioneered by SDCEP[2] and the Scottish Antimicrobial Prescribing Group (SAPG)[16].

Ten years on from the first case of a C. auris infection in Japan, the exact threat of this drug-resistant fungus in primary care dentistry remains unknown. However, where the spread of anti-fungal resistance poses a tangible threat to dental and general public health, it is hoped that this article emphasises the importance of evidence-based and appropriate anti-fungal prescriptions, acknowledging that if the UK wants to remain at the forefront of dental antimicrobial stewardship, improving the ease at which the recommendations from clinical guidance documents can be implemented in primary care by UK-based GDPs is a key, and timely, next step.

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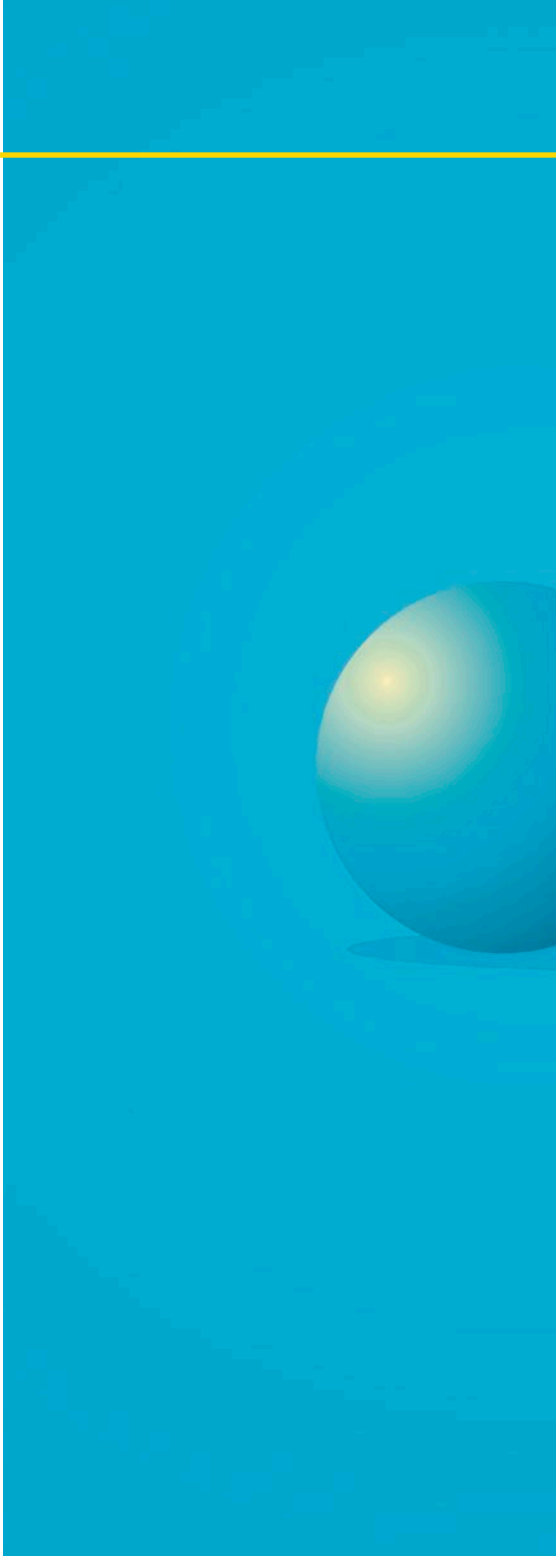
TIME WAITS FOR NO ONE

Working smarter not harder takes effort, willingness to let go of old ideas and desire to embrace change

[WORDS: ALUN K REES]



CONFUCIUS SAID: "WE HAVE TWO lives; the second begins when we realise, we only have one." This article is about time, how we use it and how we waste it. Successful people use time well. They have the same amount – there are no more minutes, hours or days available – and yet they accomplish more in their allotted span.

Time is the greatest stressor in most dental businesses, yet it should not be. Time requires thought, measurement and planning. Dentistry has '3Es'. It must be ethical, doing the right thing for the right reason; effective, it must work; and economic, it must give value for the patient and provide a profit. I would add to those my '2Es', efficient and ergonomic.

My first job in general practice was in an NHS 'amalgam factory' treating patients with relatively high needs; prevention hadn't been adopted. Quadrants of teeth were filled at a sitting, patient after patient. We worked 'six-handed' with one close support nurse and one 'floater'. I learned a lot, earned a reasonable amount and hated it. Treadmill doesn't do justice. Instead of a professional relationship with patients, I was working on a production line of mouths.

Two things happened. I read Harold Kilpatrick's book *Work Simplification in Dental Practice*, and I started my own practice – so was free to experiment. Kilpatrick's book was published in 1964 but the lessons remain. I took on board the lessons of Ellis Paul and Martin Amsel about posture and respecting your body.

One change was to say to my nurse when she asked me how long I wanted for a procedure: "Book as long as you know I will take."

That one, offhand, comment freed me from the huge pressure of my associate years. The dental mantra, 'fill the book', was left behind and I focussed on my '2Es'.

An efficient system is 'maximum productivity with minimum wasted effort or expense'. An efficient person, 'working in a well-organised and competent way'.

We looked at how I spent my time both in a macro and micro manner. There were large chunks of my days when I was not doing what only I could do, times when I could have been usefully employed not 'waiting' and the times when I was working could have been shortened.

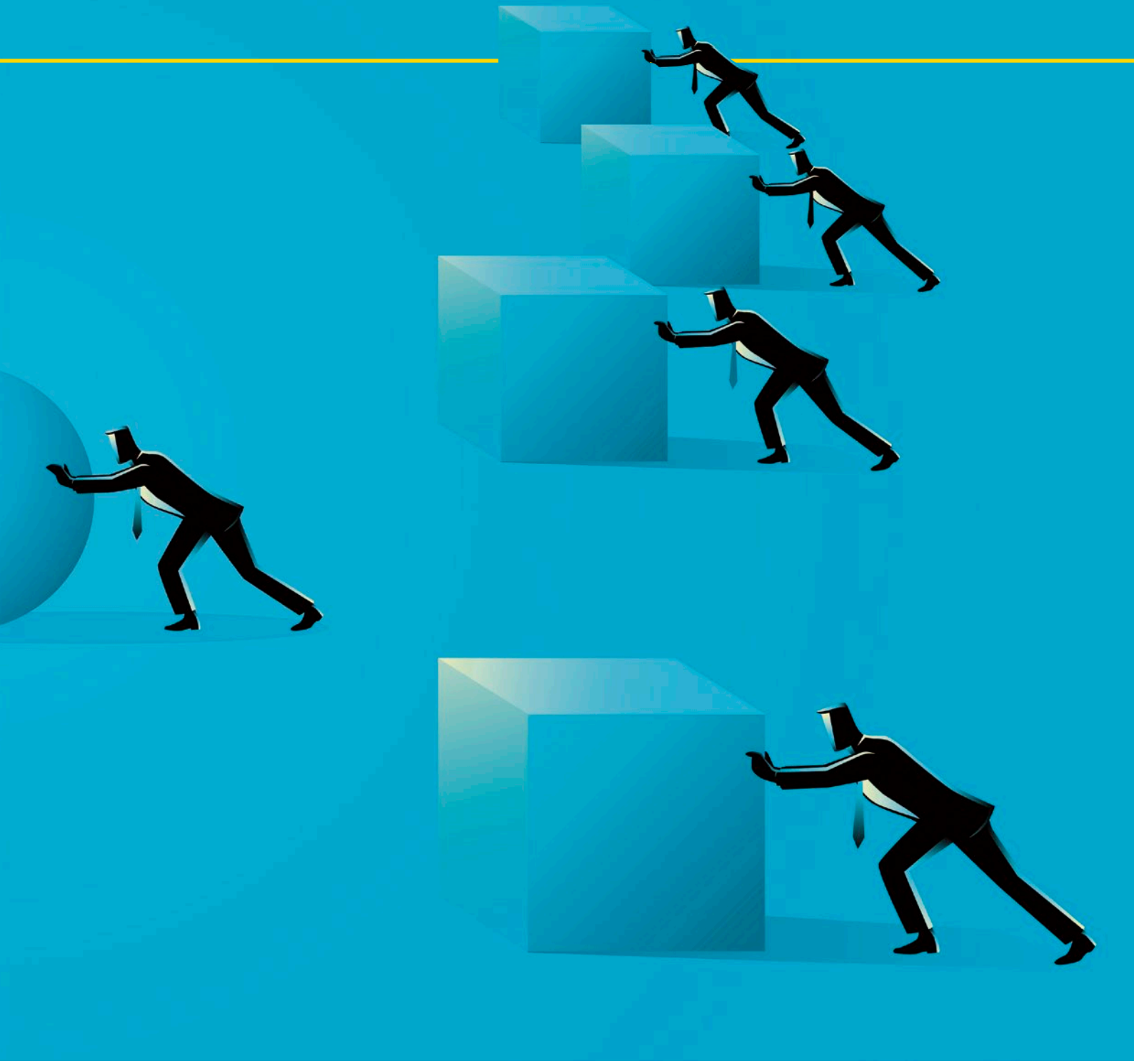
Every stage of every procedure was broken down into its constituent steps and examined. Adopting 'hygiene-led recall' meant that I was free to effectively use two rooms (three when seeing children during their sessions). Having something else to do meant that 'local waiting' time was utilised.

Working with a close support nurse meant that I never looked away when doing restorative dentistry. Using good light and magnification makes working better but moving your eyes hard work.

Great surgeons are fascinating to watch because, like musicians, their hands hardly move. I was not instinctively a great operator and knew I never would be, but I watched and learned.

Our set process for every procedure meant that my nurse always knew what to expect next. Which instrument, bur, material, and procedure. Their life was

> "I TOOK INSPIRATION FROM THE CHEFS WHOSE POLICY IS MISE EN PLACE AND PREPARE DISHES AND INGREDIENTS BEFORE THE BEGINNING OF SERVICE"



easier with no surprises. This did not happen as if by magic, it took practice, practice and more practice until my team and I were like dance partners.

I took inspiration from the chefs whose policy is mise en place and prepare dishes and ingredients before the beginning of service.

In the same way that a good chef will know that their knives are sharpened, their surfaces cleared and ingredients ready before the start of a session, my team knew a day ahead what equipment would be needed for each and every procedure and it would be ready when we started. No wandering around searching for instruments, lab work or materials when the patient was ready.

One important tool was a timer; we knew how long materials took to set and how long each stage should take. Everything from the time for topical anaesthetic to the length of time to give a painless local was known and measured.

Did it suit everyone? No, a couple of nurses during maternity breaks could not cope and would not adapt because they were 'already competent'. There was always another cab on the rank.

The result made my life easier, the procedures optimal for all concerned and stress levels lower. Was everything perfect every day? Of course not; life is never that easy. Did we keep learning and improving? Definitely. Was the system adaptable for emergencies? Certainly.

I went from a five-day to a four-day clinical week. I was less tired at the end of the day. Operative work was more satisfactory and easier. Appointment lengths worked and we rarely overran. The flexibility in the appointment book worked for us.

The cliché is work smarter not harder. It can happen but it takes effort, willingness to let go of old ideas and desire to embrace change.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

www.thedentalbusinesscoach.com

STRATEGY AND TACTICS – OFTEN CONFUSED!

Time spent on developing a clear strategy which management and staff can focus on delivering, would be time well spent

[WORDS: RICHARD PEARCE]

AT ANY ONE TIME THERE MUST BE multiple conversations happening in practices, which confuse/misuse the words 'strategy' and 'tactics'. 'Strategy' is sexy, so that's what people want to talk about. However, to give an example of the difference, sending a recall text rather than an email is NOT a strategy, it's a tactic! The strategy might be 'to increase the 12-month recall rate to 80% plus, by development of patient engagement, utilising text, email, newsletters, patient education events and involvement in at least one community event every three months'.

Being able to fundamentally understand the difference between the two 'concepts' and then developing strategies you can clearly articulate to your managers and your whole team, can give you a big advantage. Having clear strategies makes running and growing practices or groups much easier, because decision-making becomes easier.

A clear strategy makes selecting the tactics so much simpler that sometimes they are blindingly obvious. Examples will

> “DENTISTRY IS UNDERGOING HUGE CHANGES AND IT IS CRUCIAL TO HAVE A STRATEGY YOU TRULY BELIEVE IN, TO GUIDE YOU THROUGH THE NEXT FIVE YEARS”

come later. First of all, let’s define the two words:

STRATEGY – an overall campaign plan/ long-term vision, i.e. it’s ‘what’ will we do.

TACTICS – short-term actions/the actual means to achieve an objective, i.e. ‘how’ will we do it.

Strategies for success in dentistry

We live in interesting times as the large groups continue to ‘experiment’ with finding a highly profitable strategy. One of them continues to divest practices and develop its private offering while its mainstay is the NHS. Another continues to see whether it can grow its ‘connection’ with patients through a significantly expanded (by acquisition) chain of practices i.e. is dentistry a route to sell the full range of private healthcare?

Although, as an independent or small group of practices, it is worthwhile to keep an eye on the ‘big’ groups (their quarterly results briefings are online to peruse), you should be clear on your own strategy. Providing ‘caring and compassionate dentistry, in friendly and pleasant surroundings’ is not a useful strategy, as that is what every single dental practice thinks they do! Hundreds of practices actually say this on their website.

Strategy guru Michael Porter said: “Competitive strategy is about being different. It means deliberately choosing a different set of activities to deliver a unique mix of value.” As every business has limited resources, if you do more of one thing, you will have to do less of another.

Most practices still style themselves on the amount of publicly funded care they offer and this in effect provides the ‘floor’ in terms of charges. After that, we have a very few child-focused practices, specialist/ referral practices, then the vast hinterland of mixed, general practices who are adding as many ‘specialist’ services as they can find clinicians to deliver them. Most practices suffer from not having a clear strategy, one which differentiates them and makes it easier for potential patients to choose them.

A strategy is normally created to achieve market growth and this can come from one or more of the following:

1. Market penetration (sell more of what we currently sell to the same market, i.e. grow market share).
2. Market development (find new groups to sell our existing services to, i.e. expand into untapped markets).
3. Product or service development (develop current services to sell into the current market).
4. Diversification (sell new services into current and new markets)

Hence, a general practice might bring in a visiting implantologist, orthodontist and aesthetics specialist two days a month each and so they are using growth strategy 3, above. After the initial set-up costs to provide these ‘developed’ services they can retain 50 per cent of the fees that would otherwise have ‘gone’ elsewhere. This is a market growth strategy that we see commonly now.

Some corporates are trying to get brand awareness and go after that middle ground between NHS prices and fully private, with a so-called ‘independent’ price list. This is a difficult position to occupy and relies on significant cost focus but ,due to lack of NHS availability, the market size is significant.

Linked to that is the rise of market development by positioning practices in or near supermarkets and in shopping centres. This will increase as the supermarkets have to cut space but also provide a range of services which can be accessed in one visit to attract customers. A likely future development is practices within medical centres, alongside multiple medical services.

Conclusion

Strategy is different to tactics; this article has focused on strategy whereas most practices spend most of their time on tactics. Time spent on developing a clear strategy which management and staff can focus on delivering would be time well spent. It can be difficult and you might need to seek outside help which can provide a wider perspective of what is currently happening in the dental market.

The provision of dentistry is undergoing huge changes in the UK and Ireland and now more than ever it is crucial to have a strategy which you truly believe in, to guide you through the next five years.

Richard Pearce lives in Northern Ireland. Following a business career in various sectors and an MBA, he joined his dentist wife in dentistry. Richard combines his wide commercial experience with being attuned to what it is like for an associate dentist, a practice owner and a practice manager. His unique perspective ensures he can assist a practice owner with every area of the practice to create a more profitable practice and to achieve their smart objectives.

www.smartpractices.co.uk

QUALITY OF EDUCATION HAS NEVER BEEN MORE IMPORTANT

Tipton Training's standards of accreditation guarantee courses of the highest quality

The ever-changing world of dentistry presents a modern-day dentist with a unique set of challenges. Some worry about delivering UDAs to meet their NHS contract commitments, while others are concerned about complying with regulations (such as CQC).

One thing that hasn't changed and will never change, despite the new requirements that keep coming, is that dentists must still treat patients.

In the hue and cry of regulations and practice management, everyone forgets that the primary role of a dentist is to treat patients. If a dentist struggles at treating patients, we are in the age of litigation, so sooner or later a dentist will be found out.

Fortunately, thanks to GDC's 'Enhanced CPD' guidelines, the standards of dental training and education have been at the forefront of the industry. But how do you identify quality education?

ACCREDITATION: AN ASSURANCE OF QUALITY

The easiest way of identifying high-quality education is to confirm that the organisation is accredited by a reputable industry body or institution. That's why Tipton Training has adopted the approach of achieving accredited status with highly reputable independent bodies.

ACCREDITATION BY UK RECOGNISED AWARDING BODY – EDUQUAL

When Enhanced CPDs were being discussed, Tipton Training decided to target maximum compliance.

So four months before the official launch of Enhanced CPDs, Tipton Training introduced its portfolio of Level 7 (Masters level) courses.

A Level 7 course is a recognised vocational qualification and a guaranteed level of quality. This status is only awarded to courses after the curriculum, its method of delivery and assessment is verified by an independent awarding body such as EduQual.

ACCREDITATION BY ROYAL COLLEGE OF SURGEONS OF ENGLAND (RCS)

The Royal College of Surgeons of England (RCS) has awarded Centre Accreditation to Tipton Training for its courses in the UK and Ireland.

For more information about Tipton Training and its courses, please visit www.tiptontraining.co.uk, email enquiries@tiptontraining.co.uk, or call +44 (0)161 348 7849.

With this, Tipton Training becomes the first private post-graduate dental education provider in the UK to have an RCS England accredited centre (ratified by the RCS Council on 13 June 2019).

This means that in addition to the valuable skills a Tipton Training course delivers, delegates can be assured that the quality of education and methods of training have been reviewed by the best in the industry. The entire Level 7 course portfolio successfully meets the criteria and standards for accreditation.

"With this RCS accreditation, our delegates can rest assured that Tipton Training courses are of the very highest standards. Becoming the first RCS England accredited private dental education centre in UK is exciting but also reinforces our commitment to quality dental education that adds real clinical skills," explains Vivek Gupta, CEO of Tipton Training.

"Our PG Certificate and Diploma courses also have Level 7 (Masters level) status. This means that Tipton Training alumni possess a real advantage when applying for competitive positions, or when looking to expand the range of treatment options for their practice patients."

THE S-MAX PICO HANDPIECE – A REVOLUTION IN GERODONTOLOGY

Dr James Robson, Principal Dentist at Identity Dental Care, discusses the value of specialised equipment when it comes to treating elderly patients during day-to-day practice.

Increasing life expectancy and the rising demographic of older people has greatly impacted dentistry. As such there is a greater need to keep more teeth for longer. In Europe, people aged over 65 make up 16 per cent of the population – this statistic is expected to reach 27 per cent by 2050. Elderly patients are more likely to be affected by tooth loss, tooth wear, dental caries, periodontitis and oral cancer.

Dental caries, in particular, represents a major cause of the treatment delivered to elderly patients, with xerostomia (dry mouth) having an impact. As a disease, caries remains curiously active, with an observed mean increment of approximately one surface per year. These new sites may be wear facets which have decayed or root surfaces which may be trickier to access. This is where miniature dental handpieces such as NSK's S-Max Pico come in, allowing improved access and being very suitable for treating our increasing elderly demographic.

THE NEED FOR PRECISION

When I first began my career in dentistry 20 years ago, my first introduction to an NSK handpiece was of course the NAC-E slow-speed, contra-angle handpieces which were ubiquitous at the time. However, my move into private practice a few years later left me seeking more refined handpieces and in particular I came across the NSK Ti-Max range. The precision engineering, durability, light weight and excellent air and water spray make this range indispensable to how I practice.

THE PROBLEM OF RESTRICTED ACCESS

The majority of my work deals with cosmetic adult restorative dentistry. For me gerodontology is a major part of this. This element of practice presents more challenges than simply polypharmacy and oral-systemic health links. In my experience, a large number of my elderly patients may not be able to tolerate or may not wish to be reclined as fully as I would like, or may not have the stamina to remain open-mouthed for long enough to perform essential treatment.

Restricted dental access is perhaps more commonly associated with children as they have small mouths. As such, paediatric dentistry sees high usage of miniature handpieces. However, such precise technology has significantly benefited the oral care of my elderly patients, where oral access remains an issue due to limited opening and patient posture.

GERODONTOLOGY AND THE S-MAX PICO HANDPIECE

The S-Max Pico handpiece makes my life easier. Its streamlined body shape and miniature head have provided me with predictable access to the mouth, in particular while treating root caries and has improved access to the mouths of my elderly patients. This eases the frustrations of the dental team and patient alike.

The S-Max Pico has become essential to how I work. Initially developed for minimal intervention dentistry, the S-Max Pico has been designed with precision in mind. It is hard working and reliable, as I have come to expect as a Ti-Max user. I find that the small head of the S-Max Pico allows for broader viewing, which is essential when addressing restricted oral access, in particular the buccal root surfaces of posterior teeth. This handpiece feels good in the hand and although steel (opposed to titanium) does not feel significantly different to use due to its smaller size. The S-Max Pico is air driven, making it a lighter and far easier to use handpiece than its weightier, electric counterparts.

Advances in innovative handpieces are paving the way for dental procedures to be better tailored to the needs of each patient. The S-Max Pico, in my opinion, is greatly beneficial to those delivering paedodontics and gerodontology. To access narrow and restricted operational fields, whether due to size or limited opening, dentists should look to handpieces such as this, to improve the delivery of care.

James Robson qualified from Newcastle University in 1998 and spent six years working in NHS general dental practice on Teesside, followed by a similar period in private practice in York, before purchasing his own practice in 2010. James also enjoys teaching dentists, hygienists and therapists or writing for the dental or local press. He has lectured in the UK and throughout Europe. He is most passionate about tooth-coloured fillings and oral systemic health.

For more information on NSK's product range or to request a 10-day free equipment trial, contact NSK on 0800 634 1909, visit www.nsk-uk.com or contact your preferred dental dealer.

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'IT'S NOT WHAT YOU EARN, IT'S WHAT YOU KEEP'

Corrigan and Co understand the business of dentistry

Formed in 1995 by Managing Director Eamonn Corrigan, Corrigan & Co is a highly experienced accountancy practice conveniently located on the outskirts of Enniskillen, Co Fermanagh. When Eamonn returned to Fermanagh from London, where he had worked in various accountancy roles for 10 years, he took over a local practice and has expanded the business significantly.

The company has a traditional service ethos, delivering high-quality advice and information. Eamonn said: "We take pride in providing a service that meets the individual needs of each client. We understand that our clients' success is embedded in their hard work, enthusiasm and energy for their business."

Eamonn, who has more than 30 years' experience, is a qualified accountant, tax consultant, professional speaker and mentor.

His company's motto is: "It's not what you earn, it's what you keep". He is passionate about helping dentists build more profitable, more successful and more enjoyable to run businesses.

"Increased compliance, difficult customers, financial uncertainty, Brexit, long working hours, deadlines, increased competition, the economy, can all have an effect on your business life," he said.

Some years ago, Eamonn found a mentor who showed him the benefits of having a niche. He quickly recognised that dentistry would be his niche market after a conversation with his own dentist. His research found that there were few accountants who fully understood the business of dentistry and the stress involved. Corrigan & Co most certainly does.

Eamonn realised that dentists are in need of help not solely with their taxes but also understanding – setting up in practice, funding, marketing, building an asset, growth strategies, pricing and exit planning.

His top 10 tips for a profitable dental practice are:

1. Hire and retain superstars
2. Always put patients first
3. Become a leader
4. Get a grip of your numbers – Know the importance of EBITDA for your practice and your KPIs. Get your accounts produced in a timely manner and use them. Don't simply put them away.
5. Systems – At the heart of any dental practice are good systems that help to scale the business.
6. Build a digital brand – Focus on online marketing, website, SEO and social media
7. 80/20 rule (Pareto theory) – 80 per cent of your business comes from 20 per cent of clients.
8. Get help with pricing.
9. Review your funding.
10. Find a good dental accountant.

Corrigan & Co is no ordinary dental accountancy firm. We are prepared to help you every step of your journey from graduation to retirement. We are not afraid to muck in and get our hands dirty and get the job done.

‘WHY YOU, WHY US, WHY THIS, WHY NOW?’

Dr Leonard Maquire explains how he and his father created The Dentists Academy, the online resource to help you to succeed not only in serving patients, but also in the business of dentistry too

My father, Dr Derek Maguire, and I have more than 35 combined years in general dental practice as dentists, running 11 general dental practices with 47 associate dentists, 180 staff, and more than 60,000 registered NHS patients.

WHY IS THAT IMPORTANT?

Reassurance and clarity for you. As we’re both dentists, we know, first-hand, the challenges you’re facing every single day. Our real-life business experience of owning and running multiple dental practices means we know what it takes (the hard work, commitment, resilience and determination) to be successful in the business of dentistry, either as an associate dentist, or running a practice.

We understand and have faced so many of the same challenges that arise in practice.

Here’s just a snapshot of what our profession is facing today:

- Complaints are rising
- Stress is at all time high
- Time pressures are increasing
- Patient expectations are the highest they’ve ever been
- Money is not as easily earned in dentistry
- Record keeping is being scrutinised
- Costs are rising
- Indemnity isn’t getting cheaper
- Regulation is on the up
- Burnout and overwhelm are becoming common
- Litigation is increasing
- Pressure from management on performance.

So, it’s clear dentistry is rapidly shifting as a profession.

Yes, there is much opportunity – but there is also more risk than ever.

RECENTLY I READ...

....that more than one in three dentists in the United Kingdom are considering leaving the country as a result of their services being marginalised by NHS and/or Brexit. So, 18 months ago, my father and I sat down and thought: “What can we do to help ease the pressure on our colleagues and re-ignite some positivity and passion within the profession?”

This was based on the numerous private phone calls and messages we receive from other dentists (not necessarily within our organisation) relating to the above matters that highlight the common themes.

Ultimately, our aim is to foster the right learning environment to help grow exceptional dentists during this time of change and uncertainty. We looked at the areas that seem to cause the most concern, and studied them. And, really, it boiled down to being able to answer the following question... *“What is it that’s keeping dentists awake at night?”*

HANDS DOWN, THE NUMBER ONE REASON...

... is the fear of complaints and litigation. Closely followed by the complicated world of “business” in dentistry. So, this is where The Dentists Academy was born

This first part is key. We focus on non-clinical aspects of dentistry that are so vital to being successful in your practice. Occasionally some clinical points arise, which we can cover, but that’s not our primary focus.

Most dentists don’t need told how to prep a tooth for a crown, or remove decay.

BUT WE LOOK AT AREAS OF RISK AND OPPORTUNITY

Of course, we all want to make more money. But, as you and I know, we’re in healthcare. Everything we do is done with integrity. Yes, we want to earn more money – but it has to be done right. Together we look at areas that dentists don’t get much training on.

Such as:

- Challenging conversations
- Managing patient expectations
- Discussing fees with treatment plans
- Avoid complaints or handling them properly if they do arise
- Record keeping
- Compliance with regulation
- Consent.

So, in a nutshell, it’s all about personal growth and business development (remember, being self-employed, associate dentists are in business too).

All of these ideas apply to both principal and associate dentists.

Dr Leonard J Maguire BDS MFDS RCSEd MFGDP MDTFEd AFFMLM LL.M MBA CMgr MCMI PG Dip Med. Ed. FICD MFFLM Dental Surgeon. Author. Dento-Legal Adviser leonard@thedentistsacademy.com.

Dr Derek J Maguire BDS MDTFEd RCSEd FFGDP(UK) FDS RCPS(Glas) FICD Principal Dentist. Group Owner. Author.

WHAT’S INCLUDED FOR YOU AS A MEMBER?

Monthly web meets, training videos, recorded interviews Q & A sessions and access to Dr Derek Maguire and myself. Everything is recorded and stored in your password-protected area within our online portal – so you can access everything whenever it’s convenient for you.

We also have some of the best training and from my personal mentor and friend – Peter Thomson. He’s not a dentist. He’s been awarded the Lifetime Achievement Award from the Institute of Sales and Management. And has spent his lifetime in sales, leadership, management, communication skills, etc .

As a member you can log in and watch from the comfort of your own home – no need for expensive flights or accommodation as with some courses.

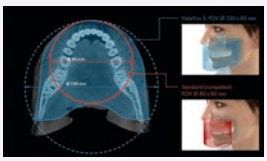
All of these videos, reports, articles, templates, interviews are all recorded and stored for you in your own personal password protected area.

So that you, as a dentist, can let go of any worry about being sued every time you put your hands in someone’s mouth, confidently and comfortably share your knowledge and expertise with your patients and enjoy more money, holidays and time off with your family

The Dentists Academy went “live” on 12 January 2019 and already we have more than 2,000 dentists with whom we are in touch with on a weekly basis, who receive the weekly blogs, articles etc. (you will too).

Currently more than 100 new dentists each week (worldwide) sign up to be part of the group.

>DÜRR DENTAL



ALL-IN-ONE DIAGNOSTICS

Dürr Dental has developed an extended version of its VistaVox S panoramic machine with six additional programmes for time-saving cephalometric exposure with minimum radiation doses, called VistaVox S Ceph.

As you'd expect from Dürr, exceptional diagnostics and ease of use are guaranteed. Alongside the 17 panoramic programmes, the VistaVox S Ceph has several orthodontic applications, including 'Lateral Head', 'Full Lateral Head', 'PA Head' and 'Waters' View'. The unit is as fast as it is smart – a scan time of just 1.9 seconds results in exceptionally sharp images using the lowest possible radiation dose due to the high-sensitivity CSL sensors. The unit can switch between 3D X-ray and Ceph boom, a process that, until now, was often cumbersome.

As with the VistaVox S, it has a perfect 3D imaging volume of 130mm (compared to 80x80mm for most), so covers the whole relevant area including rear molars, an essential requirement for diagnosing impacted wisdom teeth. Enhanced visibility does not require a higher radiation dose. Instead, a special curved path, rotating 540°, in combination with a tightly collimated fan beam and a highly sensitive Csl sensor, means a low dose is used.

Similarly to the VistaVox S, this enhanced model offers 50x50mm volumes, for indications that only require part of the jaw region to be shown, e.g. endodontic or implant treatments.

The VistaVox S Ceph offers true all-in-one capabilities for a full range of diagnostics.

>DÜRR DENTAL

SMART TECH IN SURGERY

Many of us are using smart technology within the home, to control our heating, lighting or alarm systems. Now the same pioneering technology is available to make your working life as simple. Dürr Dental has launched its new IoT (internet of things) solution called VistaSoft Monitor, to ensure that the practice runs smoothly and intuitively.

This cloud-based IoT service solution allows all connectable Dürr Dental systems to be integrated into VistaSoft Monitor, providing a clear overview of all products, including compressors, autoclaves and X-ray systems. The software is based on the following principle: monitor-transmit-analyse-act.

The units constantly monitor important operating parameters and transmit them in real time to VistaSoft Monitor, where they are analysed and then presented to the user in a clear format. Operation can be viewed centrally at a reception area PC, or decentralised in every treatment room or on a smartphone/tablet via the corresponding app.

Potential problems are detected in advance, e.g. if the fill level of the amalgam collecting container nears its maximum an alert will be sent to ensure a replacement is ordered in plenty of time. The software also flags issues that require an external response, such as a filter change on a compressor or a routine service of equipment. Operational reliability is ensured as monitoring is done through IoT rather than human assessment, leaving staff free to focus on what's most important – patients.

>DÜRR DENTAL

CLEAN WATER WITHOUT CHEMICALS

Dental treatment systems offer ideal conditions under which biofilm can form and micro-organisms such as Pseudomonas, Legionella and Cryptosporidium can flourish. These microorganisms can be exposed to the patient via the cooling water, mouth rinsing water and aerosol exposure.

Hygowater from Dürr Dental ensures the service water in your practice always meets the same stringent requirements as drinking water (consistent with advice given by the Robert Koch Institute).

Water-carrying systems in treatment units can, however, still harbour microorganisms, which can colonise and form a biofilm which adheres to the inner walls of the unit. To ensure optimal safety, microorganisms must be minimised and biofilm permanently removed from hoses and pipes.

The Hygowater system's safe and reliable processing fulfils all legal requirements for water hygiene, satisfies meticulous standards demanded by the German Drinking Water Ordinance and meets the requirements for a Class I medical device.

The compact unit is so easy to operate and its unique combination of filtration and electrolysis prevents biofilm formation. It's good for the safety of the practice and it's great for the environment, as long-term drinking water quality is ensured without the use of any chemical additives.

>DÜRR DENTAL

PARLIAMENT TALKS DENTAL TECHNOLOGY

Sir Paul Beresford MP recently held an All-party parliamentary group for dentistry and oral health at the Houses of Parliament. Visitors were encouraged to learn how modern dental technology is making fear of the dentist a thing of the past.

The event was designed to be fun and fully interactive, with members of parliament invited to feel what it's like to perform dental procedures using a realistic virtual reality unit. Those wishing to step back in time could try their hand at pulling teeth with an 18th century tooth key to see if they could get a foot-powered Victorian treadle drill spinning fast enough to get to the top of a leader board.

One manufacturer invited to attend was Dürr Dental, who took along their VistaCam intra-oral camera.

Ian Pope, Managing Director, commented, "It was great to see what technology is currently available in UK dentistry. Having worked in the industry for over thirty years, I have seen phenomenal advancements, but none more so than the pace of change in digital dentistry over the last five years. Technology is making dentistry less daunting to the public as it allows dentists to communicate more easily with patients and treat disease less invasively".

THE PERFECT PRODUCTS FOR PRECISION RETENTION

Fihol has designed and manufactured these unique, high-quality and clinically effective dental products for more than 40 years

FILPIN is the perfect product for all dentine retention pulpal pin requirements that provides maximum advantages without compromising safety, dentine integrity or retention.

It is 99.8% pure titanium, more flexible, biocompatible and compatible with all dental materials. The self-threading, self-aligning pin speeds and eases placement for self-shearing first time, every time once optimum depth is reached. Its unique thread design maximises retention strength.

After insertion FILPIN can be easily bent to suit the restoration without breaking it or the tooth. If minimal tooth structure is present pins are recommended to enhance chemical bonding provided by adhesives and when core build-up is used with less than one half of coronal tooth structure remaining.

Bonding alone is not sufficient in many situations where minimal tooth structure is present. Pins provide anti-rotational benefit when a single post is used. FILPIN is available for use by handpiece or hand placement in two sizes together with a drill to complement each size.

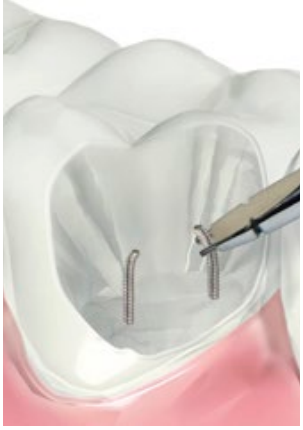
FILPOST is the only prefabricated post system that can be customised to suit the restoration for root post and core build-up.

It can be bent and shortened without risk of fracture, enabling easy insertion of multiple posts into converging canals. Engineered to be easier to place, even in difficult cases, in a faster, safer manner. There is more preserving of healthy tooth structure and it is stronger in use via its unique passive 'interlocking' system.

FILPOST is 99.8% titanium, biocompatible and compatible with all dental materials. Save time by using FILPOST as no drilling is required during placement thus avoiding risk of perforation. Its anatomical shape minimises dentine removal.

Retention grooves along the post, working together with retention grooves formed within the canal surface, by the special Universal Groover, create a unique passive interlock that strengthens retention.

FILPIN



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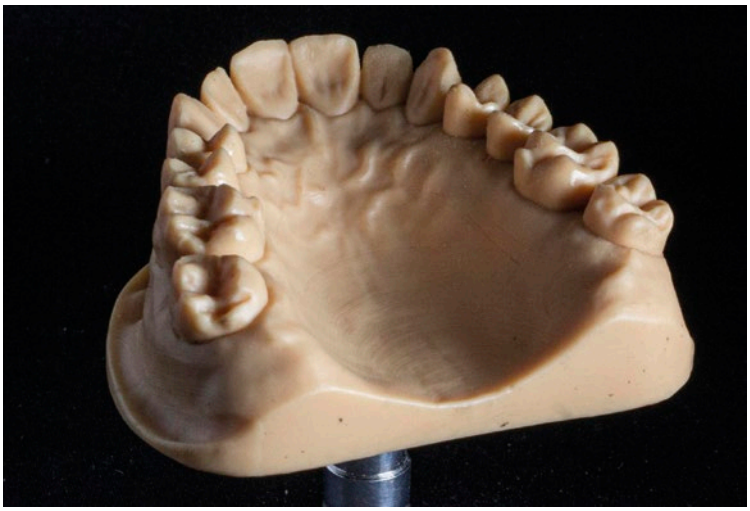

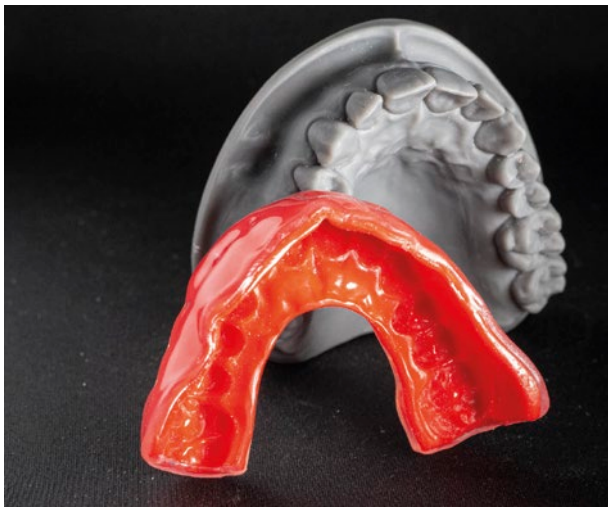

THE WAIT IS OVER! QUORIS3D IS HERE

A sister company of the well-known Quintess Denta, Quoris3D will specialise in giving dentists and technicians open and direct, online access to the advantages of 3D printing, 3D design services and the ability to purchase some of the world's leading 3D printers in the market. Quoris3D are resellers for EXOCAD, Envisiontec 3D printers / resins and in-lab scanners – with more products on the way. This project has taken more than twelve months to bring to market and involved researching and partnering with many of the leading suppliers in global 3D printing.

The Quoris3D team has been carefully chosen to include dental, 3D printing, software and technical expertise; skill sets designed to deliver a truly world-class service to their customers.

The initial 3D printed products from Quoris3D will include:

- 3D printed dentures
- Custom impression trays
- Sports shields
- Whitening trays
- Essix retainers and orthodontic aligners
- All forms of dental models
- Bite guards.

3D SURGICAL GUIDES

- Full treatment planning, design and printing available
- Printed wax patterns for chrome denture frameworks.

Quoris3D will be able to receive and work with conventional impressions, intra-oral scans or design files (in STL format) from the dentist or technician though the web portal, **www.quoris3d.com**. The expert team will then digitise and print the products, dispatching to the dental practice or laboratory within three days of receipt.

CHROME GUIDED SURGERY

Another key offering from Quoris3D will be 'CHROME Guided Surgery'. This service is a complete game changer in the growing market of full arch immediate load treatments and will offer your patients a life-changing experience with virtually-planned dental implants and teeth, typically in under three hours from anesthetic to the delivery of the provisional prosthesis.

CHROME was developed for dentists who desire planned and predictable guided All-On-X style surgery. This amazing service delivers anchored bite verification, anchored bone reduction, anchored site drilling, accurate anchored provisionalisation, and a method of transferring all surgical and restorative information for the final restorative conversion phase.

James Hamill, Clinical Director of CHROME UK and Ireland said: "CHROME is the world's leading Full Arch Guided Surgery and Restorative Solution. With over 3,000 cases completed, it is designed to simplify surgery, improve planning, predictability and results in the growing market of full arch immediate load treatments. Through Quoris3D, the service will have full telephone, online and clinical support. The popular term of 'teeth in a day' is now old news. Using CHROME, patients can now expect treatment to take three hours or less."

For more information, visit www.quoris3d.com or email info@quoris3d.com

For information on CHROME, email chrome@quoris3d.com

CHROME FULL ARCH GUIDED STABILITY

QUORIS3D Dental 3D Printing & Design

BENEFITS OF CHROME

- Experience and support from a team which has completed more than 3,000 cases
- Reassurance of 'step by step' planning
- Improved predictability and results
- Reduction in stress and guesswork
- Surgical and restorative efficiency
- Significant savings in chair-time during surgery and conversion stages
- Online ordering and simplified pricing
- Full online, telephone and clinical support with no hidden costs

Quoris3D will be exhibiting on Stand K53 at the BDIA DENTAL SHOWCASE from 17-19 October 2019 at the NEC in Birmingham. Come along to gain insights into the future of dentistry in a digital world. Learn about the many benefits to the CHROME guided surgery offering and see first-hand the exceptional quality of 3D printing for yourself.

The Quoris3D team will be on hand to offer their expert advice and answer any questions you may have. There will also be some fantastic offers on the latest equipment and 3D printed products from Quoris3D.